



The Florida Vascular Society

Resident/Fellow Membership Application

Please Return Application and Application Fees of \$50.00 to
The Florida Vascular Society, 400 Capital Circle, SE, Suite 18307,
Tallahassee, Florida 32301
(607) 754-2765 / Fax: (850) 907-1230

To the Executive Council of the Florida Vascular Society, I hereby make application for membership in the Florida Vascular Society.

Date of Application: _____

<input type="checkbox"/>	General Surgery Resident
<input type="checkbox"/>	Integrated Vascular Surgery Resident
<input type="checkbox"/>	Vascular Surgery Fellow

PERSONAL INFORMATION (please print or type)

Last Name _____ First _____ Middle _____

AMA Medical Education #: _____

FL Medical License #: _____

Date of Birth: ___/___/___ Gender: ___ Male ___ Female

Spouse Name: _____ Citizenship: _____

Sponsor: _____

MAILING INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at OFFICE HOME

Academic Practice Name _____ Cell Phone _____

Academic Address _____ Home Address _____

City/State/Zip _____ Home City/State/Zip _____

Phone _____ Office Fax _____ Home Phone _____ Home Fax _____

Academic Email Address _____ Home Email Address _____

EDUCATION

Pre-Medical School: _____ Date: _____

Degree: _____

Medical School: _____ Date: _____ MD DO

Residency: _____ Begin Date: _____ End Date: _____

Fellowship: _____ Begin Date: _____ End Date: _____

Other Educational or Research Experiences: (May Be Listed Separately) _____

Publications: (May Be Listed Separately) _____

HOSPITAL AFFILIATIONS

1. Hospital (Primary) _____

City: _____

2. Hospital (Secondary) _____

City: _____

PROFESSIONAL AND SCIENTIFIC SOCIETIES

BOARD CERTIFICATIONS

1. Name of Board: _____

Certified in _____ Date: _____

2. Name of Board: _____

Certified in _____ Date: _____

PAY BY CREDIT CARD

Amount Due: \$50.00

Name on Card: _____ Exp. Date _____

Visa Master Card American Express

Amount: _____ Card #: _____ CVV/CVC: _____

Signature: _____

The endorsement, deposit or negotiation of an applicant's check does not constitute admission into or acceptance of membership by the FVS. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a check refunding the amount submitted with the application.

REQUIRED ATTACHMENTS

1. One letters of recommendation from Program Director.
2. Copy of Residency/Fellowship Certificate
3. Submit photo as JPEG file to be used in membership directory. (Minimum file size 300px wide.)

I agree, if elected, to attend the meetings of the Society and to contribute by presentations and discussions.

Signature: _____

Typed Name: _____

SEND



CASES FOR THE PAST 12-MONTH PERIOD <u>(IF APPLICABLE)</u>	NO. OF CASES
AAA Repair by Open or Stent Graph	
Carotid Endarterectomy or Stent	
Extremity Revascularization either Open or Endovascular	
Major Vessel Repair for Trauma	
Angiography of Venous or Arterial System or Dialysis Access with or without Intervention	
Major Amputation above the Ankle or Wrist	
Dialysis Access Creation by Fistula, Shunt or Catheter	
<i>Other:</i>	
<i>Other:</i>	
<i>Other:</i>	