The Florida Vascular Society
Associate Membership Application

Please Return Application and Application Fee of $250.00 to
The Florida Vascular Society
6816 Southpoint Parkway, Suite 1000, Jacksonville, FL 32211
(904) 309-6268

☐ **ARNP** ☐ **PA** ☐ **RN** ☐ **RVT**
(Please check which allied health degree you are licensed under)

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

Date of Application:_____

Physician with whom you practice: _____

PERSONAL INFORMATION (please print or type)

_____
Last Name First Middle

Gender: ☐ Male ☐ Female Date of Birth:____/ _____ / _____

Spouse Name: _____ Citizenship:_____

Sponsoring Member of Florida Vascular Society: (Must have two sponsors).

_____

MAILING INFORMATION

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

_____
Group Practice Name Cell Phone

_____
Office Address Home Address

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

_____
Office Phone Office Fax Home Phone Home Fax

_____
Office Email Address Home Email Address

EDUCATION

School: _____ Date: _____

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

Publications: (May Be Listed Separately) _____

PRACTICE/HOSPITAL AFFILIATIONS

Practice Name: _____

Hospittal (Primary) _____

City: _____

2. Hospital (Secondary) _____

City: _____

PROFESSIONAL AND SCIENTIFIC SOCIETIES

_____

_____

FLORIDA LICENSING BOARD

Florida License Number _____ Date Issued: _____

Licensing Board:

_____

PAY BY CREDIT CARD

Amount Due: $250.00
Name on Card:_____ Exp. Date_____

☐ Visa ☐ Master Card ☐ American Express

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

Signature:_____

The endorsement, deposit or negotiation of an applicant's payment does not constitute admission into or acceptance of membership by the FVS. Payments 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. Two letters of recommendation from Florida Vascular Society members. One letter must be from the physician that you Practice with.
2. Copy of Florida License
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