Physician Application For Membership

6475 East Pacific Coast Highway, #700
Long Beach, CA 90803-4201
Phone: (800) 616-ASMS (2767) (714) 379-6262
Fax: (714) 362-9540

Referral Source: ○ Colleague ○ Meeting Attendence ○ Residency Program ○ Other: ______

Name ______ Birthdate ______

Practice Name ______

Address ______

City ______ State ______ Country ______ Postal Code ______

Office Phone ______ Office Fax ______ Mobile Phone ______

E-mail ______ Web Address ______

Home Address ______

City ______ State ______ Zip ______ Country ______

Home Phone ______ CC E-mail ______

Mailing address preference: ○ Practice ○ Home

Education

Medical School ______ Year Began ______ Ended ______

Internship ______ Year Began ______ Ended ______

Specialty Residency Training ______ Year Began ______ Ended ______

Post-Graduate Training ______ Year Began ______ Ended ______

Professional Credentials

All Applicants:
Dermatologist, Other Specialist Surgeon, or Pathologist Board Certification: ○ Yes Date ______ ○ No

M.D. and D.O. dermatologist, pathologist, and other specialist applicants for Affiliate membership must furnish photographic proof of their specialty Board certification, or the international equivalent. Applicants for Member status must furnish either proof of specialty Board certification or proof of completion of an ACGME-accredited or AOA-approved specialty Residency training, or the international equivalents. A copy of current medical license(s) must accompany each application.

Medical License Number(s):

______ Date ______ State/Country ______

______ Date ______ State/Country ______

______ Date ______ State/Country ______

Please Indicate Appropriate Membership Category

Applicants must apply initially as an Affiliate member before upgrading membership to either Associate Fellow or Fellow status membership.

Affiliate	Member	Resident
◯ Dermatologic Surgeon	◯ Dermatologic Surgeon	◯ Dermatologic Surgeon
◯ Specialist Surgeon	◯ Specialist Surgeon	◯ Specialist Surgeon
◯ Pathologist		

Please describe your training in Mohs surgery: (Attach separate sheet if necessary)

____

____

____

____

Additional Professional Data

Full-Time/Part-Time Academic Affiliation(s): ______________________________

Hospital Appointments: ______________________________

Membership in Other Professional Societies: ______________________________

If the answer to any of the following questions is "yes", please indicate complete details on a separate sheet:

A. Has your license to practice medicine in any jurisdiction ever been limited, suspended, or revoked?	◯ Yes	◯ No
B. Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed?	◯ Yes	◯ No
C. Have you ever been dismissed or resigned from a previous hospital medical staff?	◯ Yes	◯ No
D. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any local, state, or national medical society?	◯ Yes	◯ No
E. Are you currently performing Mohs Surgery in your practice?	◯ Yes	◯ No

◯ **If Board-certified, I am including photographic proof of specialty Board certification and medical license(s).**

◯ **If not Board-certified, I am including photographic proof of completion of Residency training and medical license(s).**

◯ **If a Resident, I am including photographic proof of medical license(s).**

Payment Information: $400 – Application fee and first year of membership dues (No charge for Resident applicants)

◯ Check Enclosed (U.S. Funds, Payable to ASMS) ◯ VISA/MasterCard/American Express/Discover Total ____________

Credit Card# ____________ **Expiration Date** ____________ **3 or 4-digit Verification Code** ____________

Name on Card ______________________________

Signature: ____________________ Date: ____________________