



THE WISCONSIN SURGICAL SOCIETY

Chapter of the American College of Surgeons

2018 Member Application Form

Dues year January 1 through December 31



Please type or print legibly.

Name _____

Address _____

Municipality _____ State _____ Zip _____

Phone _____ FAX _____ Email _____

√ Box	Membership Category	Explanation	Dues Amount
	Active	Current Voting Member - State Resident - Fellow of ACS _____ FACS year	\$125
	Associate	Non-Voting Member - Associate Fellow of ACS Applicant - Fellow of ACS - See application form	\$125
	Non-resident	Non-Voting Member - Currently living out-of the state of WI - FACS Fellow of ACS	\$125
	Senior	Non-Voting Member - Former Active Member, retired or over 65 yrs	\$0
	Resident/Student	Non-Voting Member - Current resident or student	\$0
AMOUNT ENCLOSED			

Thank you for your continued participation in The Wisconsin Surgical Society, A Chapter of the American College of Surgeons. Please return this form, along with your dues payment to:

The Wisconsin Surgical Society
A Chapter of the American College of Surgeons
c/o Terry & Terry Estness, Executive Directors
2408 North 67th Street
Wauwatosa, WI 53213

_____ Check or Credit card ___ MC ___ VISA ___ AMEX OR PAY ONLINE at www.wisurgicalsociety.com

Number _____ Exp. Date ____ / ____ Authorization Code _____

Name as it appears on credit card

Address _____ Municipality _____

State _____ Zip _____ Phone _____ Email _____

The Wisconsin Surgical Society
A Chapter of the American College of Surgeons



Application for Membership

Please attach to your dues payment form.

Dues \$125 per year

Dues year January 1 through December 31

Name _____ Date _____

Office Address _____

Phone _____ FAX _____ Email _____

Place and date of birth _____

Are you a Fellow of the American College of Surgeons Yes _____ Date _____

I am an applicant/candidate to be a Fellow of the American College of Surgeons.
Anticipated Fellow Year _____

PREMEDICAL EDUCATION **Dates (Inclusive)** **Degree**

College _____

College _____

MEDICAL EDUCATION **Dates (Inclusive)** **Degree**

University _____

University _____

POST GRADUATE TRAINING **Dates (Inclusive)**

Hospital _____

Hospital _____

Hospital _____

TEACHING APPOINTMENTS **Dates (Inclusive)**

University _____

University _____

HOSPITAL STAFF APPOINTMENTS	Type of Appointment	Dates (Inclusive)
Hospital _____	_____	_____
Hospital _____	_____	_____
Hospital _____	_____	_____
Hospital _____	_____	_____

CERTIFICATION SPECIALTY BOARD(S)	Dates
Board Name _____	_____
Board Name _____	_____

MEMBERSHIP in MEDICAL SOCIETIES	Dates
Society _____	_____
Society _____	_____
Society _____	_____

PUBLICATIONS	JOURNAL	Dates
Title _____	_____	_____
Title _____	_____	_____
Title _____	_____	_____
Title _____	_____	_____

ENDORSEMENT BY PRACTICING WSS Active MEMBER SURGEON

Endorsing Surgeon _____, M.D., FACS Date _____
 In addition to the signature, please print the name of your endorsing sponsor if the signature is too difficult to read.

I, _____, (please your print name) do hereby make application for membership in The Wisconsin Surgical Society, A Chapter of the American College of Surgeons. I consent to practice in an ethical manner.

_____, M.D. Date _____