☐ Active
☐ Associate

APPLICATION FOR MEMBERSHIP

Name: _____ DOB: _____
Office Address: _____
City: _____ State: _____ ZIP: _____
Telephone: _____ E-mail: _____
Home Address: _____
City: _____ State: _____ ZIP: _____

Undergraduate Education: _____ Degree: _____ Date: _____
Medical School: _____ Degree:_____ Date:_____
Internship: _____ Date:_____
Residences and Graduate Education: _____
_____
_____

How long have you been in practice in Cleveland? _____
Current Hospital Affiliation(s):
_____ City_____
_____ City_____
_____ City_____
Certification by the American Board of Surgery or its equivalent_____ Date_____
Fellowship in the American College of Surgeons or its equivalent_____ Date: _____
(Please send copy of certification or equivalent with application)
Associate applicants – date of planned board exams_____
Certification or Membership in other National Surgical Organizations:
_____
_____
Membership in local Medical Societies_____
_____

Date:_____ Signature:_____

Sponsors are to be Active Members of the Cleveland Surgical Society.

_____ _____ _____
(Please print name) (Signature) (Date)

_____ _____ _____
(Please print name) (Signature) (Date)

Recommendation of Membership Committee:_____ Date:_____
Recommendation of Executive Council:_____ Date:_____
Acceptance Letter Mailed: _____ CSS Certificate given: _____

Email to admin@clevelandsurgical.org