

Gynecologic Surgery Society



APPLICATION FOR MEMBERSHIP (Please type or print. Add additional pages if needed.)

NAME _____

ADDRESS _____

CITY: _____ STATE _____ ZIP _____

COUNTRY _____ E-MAIL _____

OFFICE TELEPHONE _____ FAX _____

OFFICE CONTACT PERSON _____

DATE OF BIRTH _____

UNDERGRADUATE SCHOOL _____ Graduation Date _____

MEDICAL SCHOOL (or other professional school) _____ Graduation Date _____

Institution

Address

Dates

INTERNSHIP _____

RESIDENCY _____

FELLOWSHIP _____

BOARD CERTIFICATION ___ Yes ___ No Certifying Institution _____ Date _____

PROFESSIONAL SOCIETIES (list) _____

LICENSED TO PRACTICE MEDICINE (current) State(s) and License #(s)

Has your medical license ever been suspended or revoked? ___ Yes ___ No
Please explain this on a separate page if the answer yes.

PROFESSIONAL ACTIVITIES (circle all appropriate)

Private Practice, Medical School Full Time, Medical School Geographic, Volunteer Medical School,
Military Practice, Private Hospital Full Time, Operating Room Nurse, Office Nurse, Industrial Nurse,
Manufacturer/Supplier, Scientist, Other (list) _____

MEDICAL SCHOOL APPOINTMENT Academic rank and school

PRACTICE (circle) Obstetrics/Gynecology, Gynecology, Reproductive Endocrinology, Reproductive
Surgery, Gynecologic Oncology, Perinatology, Urogynecology and Pelvic Floor. Other (list)

GSS MEMBERSHIP CATEGORIES (select the membership you are requesting)

___ Physician-Active Member

___ Other Medical or Industrial-Associate Member

ACTIVE GSS MEMBER SPONSOR (optional) _____

SIGNATURE _____ Date _____

MAIL OR FAX TO: GSS National Office
2440 M. St. NW Suite 801
Washington DC 20037-1404
Fax (202) 778-6195
Tel No (202) 293-5205