



# American College of Foot and Ankle Surgeons™

*Proven leaders. Lifelong learners. Changing lives.*

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## 2010 – September 2011 SURGICAL RESIDENT MEMBER APPLICATION

(PLEASE TYPE OR PRINT LEGIBLY)

NAME OF RESIDENCY PROGRAM \_\_\_\_\_

### SIGNATURE OF YOUR RESIDENCY PROGRAM DIRECTOR IS REQUIRED:

\_\_\_\_\_  
Please print Residency Program Director's Name

\_\_\_\_\_  
Residency Program Director's Signature (Required)

Residency Program Director's E-Mail Address: \_\_\_\_\_

Resident Name: \_\_\_\_\_  
(FIRST) (MI) (LAST) (SUFFIX)

PREVIOUS LAST NAME: (CHANGE DUE TO MARRIAGE, DIVORCE, ETC.) \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ Unit/Apt: \_\_\_\_\_  
(Mail is sent to Resident's Current Residence Address)

\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ HOME FAX: (\_\_\_\_) \_\_\_\_\_

CELL NUMBER \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

PODIATRIC SCHOOL GRADUATED:  APMP (AZ)  CSPM (CA)  BARRY (FL)  
 CPMS (IA)  SCHOLL (IL)  NYCPM (NY)  OCPM (OH)  TEMPLE (PA)  
 OTHER \_\_\_\_\_

YEAR PODIATRY SCHOOL GRADUATED: \_\_\_\_\_ SPOUSE'S NAME: \_\_\_\_\_

CURRENT RESIDENCY PROGRAM:  PM&S-24  PM&S-36

OTHER \_\_\_\_\_ EXPECTED RESIDENCY COMPLETION DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GENDER:  MALE  FEMALE  
(For Demographic purposes only)

*I authorize the College to make such inquiries and to obtain such information as it deems necessary or appropriate to evaluate my qualifications for membership. I understand that this information will remain confidential. I further authorize any hospital, any medical staff, any medical organization and any person, who may have information that the College deems relevant to its evaluation of my application, to provide such information to the College upon its request.*

*By providing my name, telephone number, facsimile number(s), and e-mail address(es) and signing this form, I expressly consent to the delivery of communications promoting the commercial availability or quality of any events, goods, or services from the American College of Foot and Ankle Surgeons or its licensees or vendors, whether by facsimile, electronic mail, or regular mail.*

*I will adhere to the By-Laws and Principles of Professional Conduct of the College.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Dues Information . . . Resident Dues: Now thru Sept 2011

\_\_\_ VISA \_\_\_ MasterCard \_\_\_ American Express or Check # \_\_\_\_\_ Amount Enclosed: \$ **112.00** \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_