



**American College of
Foot and Ankle Surgeons™**

Proven leaders. Lifelong learners. Changing lives.

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www.FootHealthFacts.org

2010 ASSOCIATE MEMBER APPLICATION

Being Board Qualified through the American Board of Podiatric Surgery (ABPS) is a requirement for ACFAS membership. Being a practitioner member of the American Podiatric Medical Association (APMA) is a requirement upon admission to membership in the ACFAS.

I am ABPS Board Qualified in:

- Foot Surgery _____ (date)
- RRA Surgery _____ (date)
- Foot & Ankle Surgery _____ (date)

- I am a current practitioner member of the APMA _____ (APMA Number)
- I have recently applied to my state society in _____ (State)

(PLEASE TYPE OR PRINT LEGIBLY)

NAME: _____
(FIRST) (MI) (LAST) (SUFFIX)

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

DEGREE ABBREVIATIONS: DPM, _____

PRINCIPAL OFFICE / PRIMARY ADDRESS			
CLINIC / INSTITUTION NAME: _____			
ADDRESS: _____			

(CITY)	(STATE/PROVINCE)	(ZIP CODE)	(COUNTRY) Other than USA Only
(The above address will be used for the ACFAS online Membership Directory and the FootHealthFacts.org Web site)			

TELEPHONE: Office (_____) _____

FAX: Office (_____) _____

CELL: (_____) _____

E-MAIL ADDRESS: _____

WEB SITE: Office _____

Applicant's Name: _____

2nd OFFICE NAME: _____
2nd OFFICE ADDRESS: _____

(CITY) (STATE/PROVINCE) (ZIP CODE) (COUNTRY)
Other than USA Only
PHONE: (_____) _____ FAX: (_____) _____
E-MAIL ADDRESS: _____
 PREFERRED MAILING ADDRESS BILLING ADDRESS
(Check the above boxes only if you do not want your mail sent to your principal office/primary address)

HOME ADDRESS: _____

(CITY) (STATE/PROVINCE) (ZIP CODE) (COUNTRY)
Other than USA Only
PHONE: (_____) _____ FAX: (_____) _____
E-MAIL ADDRESS: _____
 PREFERRED MAILING ADDRESS BILLING ADDRESS
(Check the above boxes only if you do not want your mail sent to your principal office/primary address)

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

YEAR GRADUATED: _____ SPOUSE'S NAME: _____

RESIDENCY: PSR-12 PSR-24 PSR-24+ PM&S-24 PM&S-36
 OTHER _____ YEAR RESIDENCY COMPLETED: _____

PRACTICE TYPE NUMBER: (Select only one)

SOLO PRACTITIONER PODIATRIC MED/SUR GROUP VA
 PARTNERSHIP EDUCATIONAL INSTITUTION HMO
 MULTI-SPECIALTY GROUP MILITARY OTHER _____

STATUS IN PRACTICE: OWNER EMPLOYEE PARTNER
(Please check only one box)

STATE(S) IN WHICH YOU ARE LICENSED TO PRACTICE: _____

DATE OF BIRTH: _____ (Month/Day/Year) GENDER: MALE FEMALE
(This section is for demographic purposes only)

