8725 West Higgins Road Suite 555 Chicago, Illinois 60631-2724 info@acfas.org 773-693-9300 phone 773-693-9304 fax acfas.org FootHealthFacts.org

ID #:	
	Office Use

Grad Year: NYCPM (NY) Kent State (OH) Temple (PA) WesternU (CA) Residency: PM&S-36 PM&S-48 PMSR PMSR/RRA Other Expected Residency Completion Date: Do you agree to list your name in the member directory on ACFAS.org? Yes No Date of Birth: Gender: Male Female (For demographic purposes only.) uthorization: I authorize the College to make such inquiries and to obtain such information as it deems necessary or appropriate to valuate my qualifications for membership. I understand that this information will remain confidential. I further authorize any hospital, any medical faff, any medical organization and any person, who may have information that the College deems relevant to its evaluation of my application, to rovide such information to the College upon its request. If y 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 rofessional Conduct of the College.	2022-2023 Resident (P	GY2 & PGY3)	Membe	er Application	n ☐ New ☐ Reinsta	atement	
Residency Director Name:	October 1, 2022 – Septeml	ber 30, 2023	*Submit your application ASAP to start receiving your benefits immediately!				
(Residency Director Signature)	Name of Residency Program:						
Name:	Residency Director Name:		E	mail:			
Previous Last Name:	Signature of Your Residency Directo	r Required:	(Re	sidency Director Signa	ature)	_	
Previous Last Name:	Name:(First)	(MIDDLE)		(LAST)	(SUFFIX)		
State: Zip:			Spouse Nar	ne:			
State: Zip:	Home Address:			Unit/Apt:			
Podiatric School: AzPod (AZ) CSPM (CA) Barry (FL) DMU (IA) Scholl (IL) Grad Year: NYCPM (NY) Kent State (OH) Temple (PA) WesternU (CA) Residency: PM&S-36 PM&S-48 PMSR PMSR/RRA Other Residency Start Date: Expected Residency Completion Date: Do you agree to list your name in the member directory on ACFAS.org? Yes No Date of Birth: Gender: Male Female (For demographic purposes only.) uthorization: I authorize the College to make such inquiries and to obtain such information as it deems necessary or appropriate to valuate my qualifications for membership. I understand that this information will remain confidential. I further authorize any hospital, any medical aff, any medical organization and any person, who may have information that the College deems relevant to its evaluation of my application, to rovide such information to the College upon its request. y providing my name, telephone number, facsimile number(s), and e-mail address(es) and signing this form, I expressly consent to the delivery of surgeons or its licensees or vendors, whether by facsimile, electronic mail, or regular mail. I will adhere to the By-Laws and Principles of rofessional Conduct of the College. Resident Dues: \$124							
Grad Year: NYCPM (NY)	Home Phone: Mo	bile:	Personal Er	nail:			
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Credit Card Number: Exp Date:/ Security Code: Name on Card: Signature: Date: Upload to: https://www.acfas.org/membershipdropbox/ Fax to: (773) 693-9304 Or mail to: American College of Foot and Ankle Surgeons, Dept. 4528, Carol Stream, IL 60122-4528 Questions? Contact Madeline Giella at (773) 444-1327 or by email to maddy.giella@acfas.org.	Resident Dues: \$124 Oc	ctober 1, 2022 – Septe	mber 30, 20	23 Please allow	up to 14 business days	for processing.	
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