American College of Foot and Ankle Surgeons®
Proven leaders. Lifelong learners. Changing lives.

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acfas.org
FootHealthFacts.org

ASSOCIATE MEMBER APPLICATION – 2019

Board Qualified status with the American Board of Foot and Ankle Surgery (ABFAS) is a requirement.

Application Type: ☐ New Associate ☐ Associate Reinstatement **ID#**: _____
Office Use

ABFAS Board Qualified in: (PLEASE TYPE OR PRINT LEGIBLY)

☐ Foot Surgery (Foot Surgery Qualified meets requirement) _____(date)
☐ RRA Surgery _____(date)

Name:

First: _____ MI/Middle: _____ Last: _____ Suffix: _____

Previous Last Name (Change due to marriage, divorce, etc.): _____

Academic Degree Abbreviations: _DPM,_____

Spouse Name: _____

Principal Office/Primary Address: *This mailing address will be used in the ACFAS directory and the FootHealthFacts.org website.*

Principal Office Name: _____

Address: _____

City: _____ ST/Province: _____ Zip: _____ Country: _____
(OTHER THAN USA)

Telephone: _____ Fax: _____

Website: _____

Primary Personal Email Address*:_____
**Email addresses do not appear in the ACFAS directory or FootHealthFacts.org.*

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Second Office Address: *This address will be used in the ACFAS directory and the FootHealthFacts.org website.*

Second Office Name: _____

Address: _____

City: _____ ST/Province: _____ Zip: _____ Country: _____
(OTHER THAN USA)

Telephone: _____ Fax: _____

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Batch # _____ Approval # _____ Amount $ _____
Office Use

Applicant's Name: _____

Home Address:_____

City: _____ ST/Province: _____ Zip: _____ Country: _____
(OTHER THAN USA

Telephone: _____ Fax: _____ Mobile/Cell: _____

Secondary Email Address:_____

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Podiatric School: ☐ AZPod (AZ) ☐ Barry (FL) ☐ CSPM (CA) ☐ DMU (IA) ☐ NYCPM (NY)
☐ Kent State (OH) ☐ Temple (PA) ☐ Scholl (IL) ☐ Western U (CA)

Year Graduated: _____

Last Residency: ☐ PM&S-24 ☐ PM&S-36 ☐ PMSR ☐ PMSR/RRA
☐ PSR-12 ☐ PSR-24 ☐ PSR-24+ ☐ PSR-36 ☐ Other: _____

Last Residency (Hospital/Clinic) _____

Last Residency Director's Name _____

Year Residency Completed: _____

Fellowship (if applicable):

Fellowship Program Name: _____

Fellowship Director's Name: _____

Length of Fellowship: ☐ 6 mos or less ☐ 1 year ☐ 2 years ☐ Other _____

Year Fellowship Completed: _____

Practice Type: (Select only one)

☐ Solo Practitioner ☐ Multi-Specialty Group ☐ Educational Institution
☐ Partnership ☐ Orthopedic Med/Sur Group ☐ Military
☐ Podiatric Med/Sur Group ☐ Hospital ☐ VA
☐ Other _____

Status in Practice: ☐ Owner ☐ Employee ☐ Partner
(Please check only one box)

State(s) in Which You Are Licensed to Practice: _____

Website Listing:

Do you agree to have your name listed in the **Members-Only Directory** on the ACFAS.org website? ☐ Yes ☐ No

Do you agree to list your principal office/primary address on the ACFAS Consumer website **FootHealthFacts.org**? ☐ Yes ☐ No

Applicant's Name: _____

Date of Birth: ____/_____/_____ (Month/Day/Year) **Gender**: ☐ Male ☐ Female
(This section is for demographic purposes only)

Certificate:

Upon approval of my application I would like my name printed on my certificate as follows:
(Initial certificate included with membership. Additional certificates may be purchased. See payment information below.)

_____, DPM, AACFAS
(Please Print Name)

All certificates are delivered to your place of business. (See next page to purchase additional certificates.)

Authorization*:*

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. To the extent consent is given on behalf of an organization, I certify that I have authority to give such consent.

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

_____ _____
Signature Required Date

Payment Information: ACFAS Membership Year is January 1 thru December 31

Application Fee: Prorated dues shown below plus a $95 processing fee.

Dues: October, November or December 2018 through 12/31/2019: $610

2019 prorated dues:
Jan: $610 **Mar:** $508 **May:** $406 **Jul:** $306 **Sep:** $204
Feb: $559 **Apr:** $457 **Jun:** $355 **Aug:** $255 **Oct 2019 – Dec 2020:** TBD

	Payment
Non-refundable processing fee:	$ 95.00
Plus Dues through 12/31/2019 (see above):	$ _____
Additional Certificates ($40 each) *Optional*:	$ _____
Total Enclosed or to be Charged:	$ _____

Check No. _____ or ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number: _____ EXP DATE: ____ /____

Security Code: _____ (3-digit VISA/MC on back / 4-digit AMEX on front)

Name of Card Holder: _____

Signature: _____ Date: _____

Return by: **Fax**: 773-693-9304 or **Mail to Lockbox**: American College of Foot and Ankle Surgeons, Department 4528, Carol Stream, IL 60122-4528.

Questions: Contact Terry Wilkinson, PhD, CAE at 773-444-1301 or by email at terry.wilkinson@acfas.org.

Your application will be reviewed and you will receive a status response within two weeks of receipt at the ACFAS office.