



FELLOW MEMBER APPLICATION – 2019

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

Application Type: New Fellow Fellow Reinstatement

ID#: _____
Office Use

ABFAS Board Certified in:

(PLEASE TYPE OR PRINT LEGIBLY)

- Foot Surgery (Foot Surgery Certified 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: _____

Telephone: _____ Fax: _____

(OTHER THAN USA)

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: _____

Telephone: _____ Fax: _____

(OTHER THAN USA)

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

Batch # _____ Approval # _____ Amount \$ _____ Office Use
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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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Solo Practitioner | <input type="checkbox"/> Multi-Specialty Group | <input type="checkbox"/> Educational Institution |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Orthopedic Med/Sur Group | <input type="checkbox"/> Military |
| <input type="checkbox"/> Podiatric Med/Sur Group | <input type="checkbox"/> Hospital | <input type="checkbox"/> VA |
| <input type="checkbox"/> 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, FACFAS
(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:	\$ <u>95.00</u>
Plus Dues through 12/31/2019 (see above):	\$ _____
Additional Certificates (\$40 each) <i>Optional</i> :	\$ _____
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.