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

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FootHealthFacts.org

2018-2019 POST-GRADUATE FELLOWSHIP MEMBERSHIP APPLICATION

April 1, 2019 – September 30, 2019

Requires enrollment in a 12-month Fellowship Program

ID#: _____
Office Use

Fellowship Program Information:

Name of Fellowship Program: _____

Fellowship Director Name: _____

Signature of your Fellowship Director (required): _____

Fellowship Completion Date: _____

Applicant Name: (PLEASE TYPE OR PRINT LEGIBLY)

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

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

Academic Degree Abbreviations: _DPM, _____

Spouse Name: _____

Home Address: _____
(Mail for those members in a Fellowship Program is sent to their current home address)

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

Phone: Home Phone: _____ Mobile/Cell: _____ Fax: _____

Email:

Personal Primary Email: _____

Secondary Email: _____

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

Graduation Year from Podiatric Medicine School: _____

Residency: ☐ PM&S-36 ☐ PMSR ☐ PMSR/RRA ☐ Other: _____

Residency Completion Date: _____

Last Residency (Hospital/Clinic) _____

Last Residency Director's Name _____

Batch # _____ Approval # _____ Amount $ _____
Office Use

I am ABFAS Board Qualified in:

- ☐ Foot Surgery _____ (date)
- ☐ RRA Surgery _____ (date)
- ☐ Not ABFAS Board Qualified, but plan on taking exam _____ (date)
- ☐ Not ABFAS Board Qualified and do not plan on seeking status

Website Listing:

If you hold ABFAS Board Qualified status, do you agree to list your principal office/primary address on the ACFAS Consumer website FootHealthFacts.org? ☐ Yes* ☐ No

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

***Principal Office/Primary Address**: *This address will be used in the ACFAS directory and the FootHealthFacts.org website. The address can be provided at a later date if you start employment in a practice during your Fellowship.*

Principal Office Name: _____

Address: _____

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

Telephone: _____ Fax: _____

*Applicants who are verified to be Board Qualified with ABFAS will be provided with the designation of "AACFAS". If your status is "incomplete" or no status, you will not be provided with the "AACFAS" designation.

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 Post-Graduate Fellow certificate as follows:
(Initial certificate included with membership.

_____, DPM, AACFAS
(Please Print Name)

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

Dues Information: Post-Graduate Fellow Dues: **$112** for April 1, 2019 – September 30, 2019.

☐ VISA ☐ MasterCard ☐ American Express or Check # _____ Amount Enclosed: **$112**

Credit Card Number: _____ EXP DATE: ____ /____ Security Code: _____

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 Laura Kuhn at 773-444-1327 or by email at laura.kuhn@acfas.org.

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