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

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

2018-2019 Resident (PGY2 & PGY3) Member Application

April 1, 2019 – September 30, 2019 * ☐ New ☐ Reinstatement

Name of Residency Program: _____

Residency Director Name: _____ **Email**: _____

Signature of Your Residency Director Required: _____
(Residency Director Signature)

Name: _____
(First) (Middle Name or MI) (Last) (Suffix)

Previous Last Name: _____ **Spouse's Name**: _____

Home Address: _____ **Unit/Apt**: _____
(Mail is sent to Resident's Local Home Address)

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Home Fax**: _____

Mobile Phone: _____ **Personal Email**: _____

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

Grad Year: _____

Residency: ☐ PM&S-36 ☐ PM&S-48 ☐ PMSR ☐ PMSR/RRA ☐ Other _____

Residency Start Date _____ **Expected Residency Completion Date**: _____

Date of Birth: _____ **Gender**: ☐ Male ☐ Female
(For demographic purposes only.)

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.

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

_____ _____
Resident Signature Date

Dues Information: Resident Dues: $60 Apri; 1, 2019 thru September 30, 2019

☐ VISA ☐ MasterCard ☐ American Express or Check # _____ Amount Enclosed: $ _____ **$60**_____

Credit Card Number: _____ Exp. Date: _____/_____ Sec Code: _____

Name on Card: _____ Signature: _____

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, Membership Manager at 773-444-1327 or by email at laura.kuhn@acfas.org.

Batch # _____ Approval # _____ Amount $ _____
Office Use