



# New Jersey Chapter – American College of Surgeons

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## MEMBERSHIP APPLICATION

Name \_\_\_\_\_ (Exactly as on NJ Medical License)

Fellowship Number \_\_\_\_\_

NJ Medical License # \_\_\_\_\_ Date Issued \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ Telephone # \_\_\_\_\_  
(Group Name – if applicable)

\_\_\_\_\_ Fax # \_\_\_\_\_  
(Street)

\_\_\_\_\_ E-mail Address \_\_\_\_\_  
City, State, Zip

Medical Education \_\_\_\_\_  
(School/Location) (Degree) (Year) (Gender)

Specialty Areas – Primary \_\_\_\_\_

Board Certifications \_\_\_\_\_

Active Hospital Appointments \_\_\_\_\_

Please answer the following. Attach a full explanation to any questions answered “yes”.

Have you ever been convicted of a felony crime? Yes \_\_\_ No \_\_\_

Has your license to practice medicine in any jurisdiction ever been suspended or revoked? Yes \_\_\_ No \_\_\_

Have you ever been the subject of disciplinary action by a medical license board, medical Society or hospital staff? Yes \_\_\_ No \_\_\_

### PAYMENT METHOD

**July 1, 2019 – June 30, 2020 Dues = \$200.00**

Please make check payable to: New Jersey Chapter, American College of Surgeons

#### Credit Card Information

Type of Credit Card: \_\_\_\_\_ Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

I hereby release and hold harmless from any liability or loss the New Jersey Chapter, American College of Surgeons, their officers, agents, employees, and members for acts performed in good faith and without malice in connection with evaluating any application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations who in good faith and without malice provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership. Furthermore, I attest to the accuracy of information supplied on this application and understand that falsification of any information may result in denial or revocation of membership.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

Mail to: New Jersey Chapter, ACS, 36 Elm Street, Suite 5, Morristown, NJ 07960

# NEW JERSEY CHAPTER, AMERICAN COLLEGE OF SURGEONS

*Please update/provide the following information:*

Additional office(s): \_\_\_\_\_  
\_\_\_\_\_

Additional Phone #'s: \_\_\_\_\_  
\_\_\_\_\_

Insurance Accepted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicare: Yes No

Medicaid: Yes No

Special Procedures: \_\_\_\_\_  
\_\_\_\_\_

Group Name: \_\_\_\_\_

Partners: \_\_\_\_\_  
\_\_\_\_\_

Hospital Affiliations: \_\_\_\_\_  
\_\_\_\_\_

Languages: \_\_\_\_\_

Additional Information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_