

NEW YORK STATE NEUROSURGICAL SOCIETY, INC.

Membership Application

Print or use typewriter. Complete each space. Write "none" if question is not applicable.

Date of Application: _____

1. I hereby make application (circle one):

Active Associate Special Honorary Senior Membership

2. Name: _____ 3. Date of Birth: _____
(Last) (First) (Middle)

4. Mailing Address: _____
(Number) (Street)

(City) (State) (Zip) (County)

Phone: _____ E-Mail _____

5. Location of principal professional activity: _____
(City and State or County)

6. Sex: Male Female

7. Medical Education: _____
(School) (City)

(State or County) (Years) (Degree)

8. Residency: _____

(Location and Dates)

9. Fellowship: _____

(Location and Dates)

10. Licensed to practice medicine in: _____
(State and Date) (License No.)

(State and Date) (License No.)

(State and Date) (License No.)

ECFMG _____
(Type and Date)

11. Membership in: _____ County Medical Society

12. Membership in American Medical Association: Yes No Date: _____

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13. Previous Membership in Neurosurgical or Component Society:

(Society and Dates)

14. Certification by American Board of Neurological Surgeons: _____

(Date)

Other: _____

(Name and Date)

15. Present Appointments:

(Indicate Institutions and Dates)

FOR PHYSICIANS IN FULL TIME MILITARY SERVICE ONLY

16. _____

(Rank)

(Duty Station)

(Branch)

17. Date and Entry into Active Duty: _____ Expected Date of Discharge: _____

SPONSORS: (Two Active Members of the Society)

A. _____
(Typed Name) (City and State) (Signature)

B. _____
(Typed Name) (City and State) (Signature)

Applicants Signature: _____

FOR NEUROSURGICAL SOCIETY USE ONLY

Approved by: _____ Membership Committee
(Signature)

Elected to: _____ membership on _____
(Category) (Date)

Comments: _____

RETURN THE COMPLETED APPLICATION WITH THE REGISTRATION FEE TO:

REGISTRATION FEE FOR ATTENDING: \$200

REGISTRATION FEE FOR RESIDENTS: \$100

New York State Neurosurgical Society

Po Box 359

Hartsdale, NY 10530