AMERICAN COUNCIL OF ACADEMIC PLASTIC SURGEONS
Membership Application

500 Cummings Center, Suite 4550
Beverly, MA 01915
Phone: 978-927-8330 – Fax: 978-524-0461
http://www.acaplasticsurgeons.org/

I hereby apply for **ASSOCIATE** Membership

Associate members shall be individuals who are teaching faculty not yet certified by the ABPS or the RCPS(C), other educators and plastic surgery residency program coordinators committed to plastic surgery education and who have a special interest in the purposes and activities of the Council. Associate members are encouraged to attend functions of the Council but shall not be eligible to vote and/or hold office in the Council.

Date: _____

Name: _____ DOB: _____
(Last) (First) (MI) (MM/DD/YYYY)

Office Address: _____
(Institution) (Address)

_____
(City) (State) (Zip)

Phone:_____ Fax: _____

Home Address: _____

_____
(City) (State) (Zip)

Phone:_____ E-mail: _____

Position :_____

Institution _____Date appointed _____

Program Director Name: _____
(Required, must be an Active member of ACAPS)

American Board Certification or Canadian Fellowship Status: *if applicable)*

Surgery: Date _____Board _____

Plastic Surgery: Date _____ Board _____

Other Specialty: Date _____ Board _____

Plastic Surgery Recertification: Date _____

Professional Education and Training:

Medical School _____ Date of Graduation _____

Residency / Fellowship Training (list all surgical training): *if applicable*

1. Institution _____

Dates _____ Position _____

Chief of Service _____

2. Institution _____

Dates _____ Position _____

Chief of Service _____

3. Institution _____

Dates _____ Position _____

Chief of Service _____

4. Institution _____

Dates _____ Position _____

Chief of Service _____

Membership in Organizations (Please check next to appropriate organizations) *if applicable*

- ☐ Fellow, American College of Surgeons Date _____
- ☐ American Society of Plastic Surgeons Date _____
- ☐ American Association of Plastic Surgeons Date _____
- ☐ Plastic Surgery Research Council Date _____
- ☐ American Society for Surgery of Hand Date _____
- ☐ American Assn. for Hand Surgery Date _____
- ☐ American Burn Association Date _____
- ☐ American Society for Aesthetic Plastic Surgery Date _____

***PLEASE ATTACH A CURRENT COPY OF YOUR CURRICULUM VITAE.**

I certify that the information provided in this application is correct to the best of my knowledge. I agree to abide by the rules and regulations of the ACAPS if elected to membership.

Signed: _____ Date: _____

Please send completed application to admin@acaplasticsurgeons.org