# AMERICAN COUNCIL OF ACADEMIC PLASTIC SURGEONS
## Membership Application

500 Cummings Center, Suite 4400
Beverly, MA 01915
Phone: 978-927-8330 – Fax: 978-524-0461
http://www.acaplasticsurgeons.org/

I hereby apply for **INTERNATIONAL** Membership

* **International members** shall be teaching faculty in training programs in plastic surgery and/or fellowships in plastic surgical specialties approved by the accrediting body of their home county/region or who have qualifications as determined by the Board of Directors. International member applicants need to be sponsored by an ACAPS member who will write a letter of recommendation on their behalf. International members shall have the right to serve on committees, or, in their absence, designate a proxy to represent them, but do not have the right to vote.

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: __________________________________________________

**Certification or Accreditation**

Surgery: Date _________________Board ___________________________________________________

Plastic Surgery: Date _________________ Board ___________________________________________________

Other Specialty: Date _________________ Board ___________________________________________________

**Professional Education and Training:**

Medical School ____________________________________________ Date of Graduation ____________

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

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**

____________________ Date ____________________
____________________ Date ____________________
____________________ Date ____________________
____________________ Date ____________________

**ACAPS MEMBER SPONSOR:** ____________________

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

☐ **ATTACH A SEPARATE PARAGRAPH STATING THE SPECIFIC REASON(S) YOU ARE INTERESTED IN BECOMING AN ACAPS MEMBER.**

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: ____________________

☐ I confirm this applicant's professional competence and moral and ethical standing and endorse this application for membership.

Name: ____________________ Signature ____________________
(Chairman of Surgery, Dean of Medical School or Hospital Administrator sponsoring the residency program.)

Please send completed application to admin@acaplasticsurgeons.org