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 **MEDICAL STUDENT** Membership

Medical Student members shall be individuals who currently training in a medical school approved by the LCME who have demonstrated interest in and commitment to plastic surgery education. Medical Student members are encouraged to attend functions of the Council but **NOT** be eligible to vote.

Date: ____________________________

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

Medical School Address: ____
(Institution) (Address)

____
(City) (State) (Zip)

Phone:____ Email: ______________________________

Expected Date of Graduation ______________________

Home Address: ____

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(City) (State) (Zip)

Phone:______________________________ E-mail: ____

ACAPS Member Sponsor: ____
(Must be an Active member of ACAPS)

If You Do Not Have Access To A Sponsor Please Assign Me An ACAPS Mentor ___________

Membership in Medical Student Category for the following Organizations (Please check next to appropriate organizations) *if applicable*

- ☐ 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.**
***PLEASE ATTACH A LETTER OF GOOD STANDING FROM YOUR MEDICAL SCHOOL ADMINISTRATIVE OFFICE**

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