American Society of Anesthesiologists

520 N. Northwest Highway • Park Ridge, IL 60068-2573 • (847) 825-5586 • fax (847) 825-1692 • www.asahq.org

Resident Member Application

Date of application: _____

1. ASA membership requires component society membership for U.S. members. If you are active duty military personnel and/or joining the USSA (Uniformed Services Society of Anesthesiologists) component, please make sure to complete #15.

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

4. **Home Address** *(required)* **Is this your primary address?** ❑ Yes ❑ No

_____
(Number) (Street)

_____
(City) (State) (Zip Code) (Country)

Business Address *(required)* **Is this your primary address?** ❑ Yes ❑ No

_____
(Company Name) (Department)

_____
(Number) (Street)

_____
(City) (State) (Zip Code) (Country)

Billing Address for ASA Dues Statement: ***If not completed, statement will be sent to Primary Mailing Address***

_____
(Company Name) (Department)

_____
(Number) (Street)

_____
(City) (State) (Zip Code) (Country)

Office Telephone* _____ ❑ Do Not Display

Office Fax* _____ ❑ Do Not Display

E-mail Address* _____ ❑ Do Not Display

5. **State of Principal Professional activity** *(e.g., Florida)***:** _____

6. **Gender:** ❑ M ❑ F

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

_____
(City) (State) (Country) (Years) (Degree)

8. **Internship:** _____ 9. **Residency:** _____
(Location and Dates) (Location and Dates)

10. **Licensed to practice in:** _____, _____
(State and Date) (State and Date)

11. **Certification by:** ABA: _____ Other Certification: _____
(Date) (ABA I.D. Number) (Date) (Number)

12. **Present Appointments:** _____
(Indicate Institutions and Dates)

13. **Applicants Signature:** _____

Note: Application continues on back of form.

***Unless indicated in the "Do Not Display" box, this information will be included in your online directory listing that can be viewed by other ASA members.**

FOR PHYSICANS IN FULL–TIME TRAINING

14. Present full-time training: _____
(Hospital)

_____
(City) (State) (Date Begun) (Proposed Termination Date)

_____ _____
(Program Director-Please Print) (Program Director Signature)

FOR PHYSICIANS IN FULL-TIME MILITARY SERVICE

15. _____ _____ _____
(Rank) (Duty Station) (Branch)

PAYMENT INFORMATION

16. If paying by credit card, your card will be charged upon approval of your application.

The credit card number you supplied on this application may also be used to charge your component society dues, if the component accepts credit cards and charges dues. This will be a separate transaction on your statement. Those components that do not accept credit card payments and charges dues will contact you for payment of component dues. Please contact ASA Member Services at (847) 825-5586 with any questions. ***Dues are based on the calendar year.***

Note: Dues must accompany application. Dues payments are based on a calendar year. Please pay only the amount indicated based on the date of your application. Dues payments are not refundable.

___ $25 Annual Dues ___ $12.50 After June 30th

❑ American Express ❑ MasterCard ❑ VISA

Credit Card Number: _____

Expiration Date: _____ Card Holder Name: _____
(month/year) (please print)

Signature_____

MEMBERSHIP IN GOOD STANDING OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS
REQUIRES ADHERENCE TO THE ASA "GUIDELINES FOR THE ETHICAL PRACTICE OF ANESTHESIOLOGY."

TO BE COMPLETED BY COMPONENT SOCIETY SECRETARY

Approved as a(n) _____member in good standing of the
(Category)

_____ Society of Anesthesiologists.
(Component)

_____ _____
(Date) (Secretary of Component Society)