



**Active 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 #14.

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 PHYSICIANS IN FULL-TIME MILITARY SERVICE**

14. \_\_\_\_\_  
(Rank) (Duty Station) (Branch)

**PAYMENT INFORMATION**

15. 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. This will be a separate transaction on your statement. Those components that do not accept credit card payments will contact you for payment of component dues. Membership in the ASA is contingent upon component society membership. Please contact ASA Member Services at (847) 825-5586 with any questions. **Dues are based on the calendar year.***

**Note: Dues of \$625.00 must accompany application; the prorated amount is \$312.50 after June 30.**

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)