(Please print or type)

International Resident/Trainee Membership Application

**Required fields—applications will not be accepted if left blank*

Name:_____ Date:_____
Full Legal Name

Professional Credentials:_____ *Date of Birth:_____ *Gender: ☐ Male ☐ Female
MM/DD/YY

*Home Address:_____

City:_____ State:_____ ZIP:_____ Country:_____

*Personal Email:_____ Institution Email:_____

*Personal Tel:_____ ☐ Home ☐ Cell Work Tel:_____

*Medical School:_____ Begin/Graduation:_____
MM/YY - MM/YY

City:_____ State:_____ Country:_____

*Residency Institution Name:_____

*Residency Institution Address:_____

*City:_____ *State:_____ *ZIP:_____ *Country:_____

*Date Started:_____ *Date of Completion:_____
MM/YY *MM/YY*

If applying as a resident:

Program Director or Coordinator:_____

Program Director or Coordinator Phone:_____

Program Director or Coordinator Email:_____

If applying as a fellow trainee:

Fellowship Program Institution:_____

Fellowship Type:_____

Fellowship Institution Address:_____

City:_____ State:_____ ZIP:_____ Country:_____

Date Started:_____ Date of Completion:_____
MM/YY *MM/YY*

Program Director:_____

Program Director Phone:_____ Program Director Email:_____

Payment Method

Note: Dues must accompany application. Membership is based on a calendar year running from January 1–December 31. Please pay only the amount indicated based on the date of your application. Dues payments are not refundable.

☐ **$25 (USD)** Annual Dues ☐ **$12.50 (USD)** After July 31

☐ American Express ☐ MasterCard ☐ VISA

Total Amount:_____Name on Card:_____

Credit Card Number:_____ Expiration Date:_____Card ID:_____

Signature:_____

Membership in good standing of the American Society of Anesthesiologists
requires adherence to the ASA "Guidelines for the Ethical Practice of Anesthesiology."