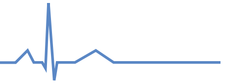
American Society of Anesthesiologists



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

Date of application:____________________

1. I hereby make application for (check one) ❑ **ACTIVE** ❑ **AFFILIATE** ❑ **RESIDENT** membership
   (ASA Membership requires component society membership for U.S. members)

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* Office Fax*
   ______________ ❑ Do Not Display ______________ ❑ 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)

Note: For Resident Application only, dues of $25.00 must accompany application; $12.50 after June 30.

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. 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.

❑ 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)