



Instructions for Application for Membership in The Chicago Surgical Society

Eligibility Requirements: Applicants are eligible for Fellowship if he or she is 30 years of age, a graduate of 5 years' standing from a recognized medical college, holds a certificate of a surgical American Specialty Board (or its equivalent as determined by the Executive Council) and has established a reputation as a practitioner, author, teacher, or original research worker in surgery.

1. All applications are made at the invitation of a member who becomes the chief sponsor of the applicant.
2. The sponsor should obtain two endorsers to sign the application. Both endorsers must be members of The Chicago Surgical Society.
3. The sponsor and the endorsers should each send a letter of recommendation for the applicant directly to the Secretary of the Society to the address shown below.
4. A) The applicant should complete all portions of the application form.
B) No pages are to be attached to the application, with the exception of bibliography and an optional photograph.
C) Both the year and the number of the applicant's Specialty Board Certification(s) should be given, as well as the expiration date. Certifications must be current.
D) Applicant's current curriculum vitae should be submitted with their application
5. All publication listings should be given in standard form and chronological order, and include all authors' names in the order in which these names appear in the original publications.
6. The following application should be typed or hand written and printed and signed by the applicant and sponsors, and should be sent to the following address:

The Chicago Surgical Society
Attn: Secretary
P. O. Box 2432
Des Plaines, IL 60017-2432
Fax: 847-954-2367

e-mail: chicagosurgical@gmail.com

The Chicago Surgical Society
Application for Membership

TO THE EXECUTIVE COUNCIL OF THE CHICAGO SURGICAL SOCIETY:

I hereby make application to the Chicago Surgical Society for:

Active Fellowship Non-Resident Fellowship
(Metropolitan Chicago Area) (Other)

Name
(Last Name) (First Name) (Middle Name)

Place of Birth Date of Birth

Residence
(Number, Street, City, State, Zip)

Office
(Number, Street, City, State, Zip)

Telephone () Fax ()

E-mail

To the Executive Council of the Chicago Surgical Society:

We vouch for the character and standing of M.D.
of and recommend his/her selection.

(Office)
Sponsor

Endorser

Endorser

Application Received by Secretary
(Month, Day, Year)

Action of Executive Council

Action of Society

To the Executive Council of the Chicago Surgical Society:

FOR YOUR INFORMATION I SUBMIT THE FOLLOWING DATA CONCERNING MY MEDICAL AND SURGICAL TRAINING.

1. Premedical Education:

| | | | | | | |
|--|------|--|----|--|--------|--|
| | From | | to | | Degree | |
| | From | | to | | Degree | |

(Universities or Colleges)

2. Medical Education:

| | | | | | | |
|--|------|--|----|--|--------|--|
| | From | | to | | Degree | |
| | From | | to | | Degree | |

(Medical Schools)

3. Internship: _____

(Hospitals and Dates)

4. Residency and Fellowship Training:

a) GIVE NAME OF SURGICAL RESIDENCY PROGRAM, LOCATION, AND DATES SERVED. _____

b) GIVE NAME OF PROGRAM, LOCATION AND DATES WHERE CHIEF RESIDENCY SERVED. _____

c) GIVE NAME OF PROGRAM, LOCATION, AND DATES FOR ANY FELLOWSHIP TRAINING. _____

D) GIVE DATES FOR ANY DEDICATED RESEARCH TIME AND INCLUDE LOCATION AND NAME OF PERSON SUPERVISING

RESEARCH _____

5. PRIOR HOSPITAL OR MEDICAL CENTER ASSOCIATIONS (GIVE DATES, HOSPITAL APPOINTMENTS, AND TITLES):

6. PRESENT HOSPITAL ASSOCIATIONS (GIVE DATES, HOSPITAL APPOINTMENTS, AND TITLES):

7. PRESENT MEDICAL SCHOOL ASSOCIATIONS (GIVE DATES AND ACADEMIC RANKS):

8. Surgical Specialty _____

9. Percentage of Practice Limited to Surgery:
10. Area of Clinical Interest
11. Member of the Following Medical and Surgical Societies:
12. Are you a Fellow of the American College of Surgeons? Date
13. a) Do you possess the certificate of the American Board of Surgery?
(Number, Date, and Expiration Date)
- b) Are you certified by any other American Board?
(Number, Date, and Expiration Date)
- If not certified, has your application been accepted by an American Board?

(Date of Acceptance) (Specific Board)
14. Give examples of contributions to your specialty, hospital, or community outside of your clinical surgical practice (i.e. service to your specialty organizations, service on hospital committees, or special activities within the community):
15. Do you agree to attend the meetings of the Chicago Surgical Society, and to contribute to the meetings by presentation of papers, and by entering into the discussions?
16. I HEREBY CERTIFY THAT THE ABOVE ANSWERS ARE TRUE AND CORRECT, AND I HEREBY PROMISE THAT I HAVE NOT AND WILL NOT PRACTICE THE DIVISION OF FEES, EITHER DIRECTLY OR INDIRECTLY, IN ANY MANNER WHATSOEVER.
- SIGNED M.D. Date

The submission can be made by fax 847-954-2367 or email chicagosurgical@gmail.com