New Jersey Chapter – American College of Surgeons

36 Elm Street, Suite 5, Morristown, NJ 07960
(973) 539-4000 * FAX: (973) 539-9493
Email: njsurgeons@aol.com

MEMBERSHIP APPLICATION

Name ______________________________(**Exactly** as on NJ Medical License)

Fellowship Number ______________________________

NJ Medical License # __________Date Issued __________ Birth Date __________ Sex ______

Address ______________________________ Telephone # ______________
(Group Name – if applicable)

______________________________ Fax # ______________
(Street)

______________________________E-mail Address ______________
City, State, Zip

Medical Education ______________________________ _____ _____ _____
(School/Location) (Degree) (Year) (Gender)

Specialty Areas – Primary ______________________________

Board Certifications ______________________________

Active Hospital Appointments ______________________________

Please answer the following. Attach a full explanation to any questions answered "yes".

Have you ever been convicted of a felony crime? Yes ___ No ___
Has your license to practice medicine in any jurisdiction ever been suspended or revoked? Yes ___ No___
Have you ever been the subject of disciplinary action by a medical license board, medical Society or hospital staff? Yes ___ No ___

PAYMENT METHOD

July 1, 2020 – June 30, 2021 Dues = $200.00

Please make check payable to: New Jersey Chapter, American College of Surgeons

Credit Card Information

Type of Credit Card: ______________ Credit Card Number:______________

Expiration Date:__________ Security Code:__________

Billing Address:______________________________

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I hereby release, and hold harmless from any liability or loss, the New Jersey Chapter, American College of Surgeons, their officers, agents, employees, and members for acts performed in good faith and without malice in connection with evaluating any application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications form membership. Furthermore, I attest to the accuracy of information supplied on this application and understand that falsification of any information may result in denial or revocation of membership.

Applicant's signature ______________________________ Date ______________

Mail to: New Jersey Chapter, ACS, 36 Elm Street, Suite 5, Morristown, NJ 07960

NEW JERSEY CHAPTER, AMERICAN COLLEGE OF SURGEONS

Please update/provide the following information:

Additional office(s):____

____

Additional Phone #'s:____

____

Insurance Accepted:____

____

____

Medicare: ☐Yes ☐No Medicaid: ☐Yes ☐No

Special Procedures:____

____

Group Name: ____

Partners:____

____

Hospital Affiliations:____

____

Languages:____

Additional
Information:____

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