

APPLICATION FOR ASSOCIATE MEMBERSHIP ONLY

(Please complete both sides)



Name _____
LAST FIRST MI DEGREE

Date of Birth _____ Gender: Male Female

Current Academic Affiliation and Title _____

Office Address _____

Phone _____ Fax _____ E-mail _____

Home Address _____

Preferred Mailing Address: Office Address Home Address

EDUCATION

Highest Degree Earned _____ Year _____

Institution _____

Please check one of the following: Physician Assistant Perfusionist Nurse Nurse Practitioner

Practice Administrator Data Manager Other

CERTIFICATION

American Board of Cardiovascular Perfusion: Certificate No. _____ Year _____

National Commission on Certification of Physician Assistants: Certificate No. _____ Year _____

Nursing Certificate _____ Certificate No. _____ Year _____

Other Certification as Applicable:

Certifying Body _____ Certificate No. _____ Year _____

Certifying Body _____ Certificate No. _____ Year _____

PRACTICE (if applicable)

Percentage of Work Devoted to Cardiothoracic Surgery _____ %

Percentage of Work Devoted to the Following Sub-Specialties:

Adult Cardiac _____ % General Thoracic _____ % Congenital Heart _____ % Vascular _____ % Other _____ %

Practice Setting: Academic Hospital Private Other (if so, explain) _____

SPONSORS *(Please note that you are responsible for contacting sponsor)

1. _____
NAME ADDRESS

Additional Applicant Information:

1. State(s), Province(s), or Country(ies) in which Licensed/Certified (if applicable) _____

License/Certificate Number(s) _____ Date(s) Originally Issued _____

Are there any current restrictions on this license/certification? _____
(If yes, please submit details on a separate sheet of paper and attach this to the application.)

2. Have you ever had your license/certification or any right restricted, rescinded or placed on probation through governmental action or voluntary surrender? Yes No N/A

3. Current Hospital or Health System Affiliation _____

4. Current Employer (if different from #3. above) _____

In furtherance of my application for membership in The Society of Thoracic Surgeons, I hereby request and authorize any hospital, health system, or other entity where I now have, had, or have applied for employment or other affiliation, and any professional organization of which I am a member or to which I have applied for membership, and any person who may have information (including medical records, patient records, and reports of committees) which is deemed by the Society to be material to its evaluation of my fitness for membership to provide such information to representatives of the Society upon their request. I agree that communications of any nature made to the Society regarding my fitness for membership shall be made in confidence and shall not be made available to me under any circumstances. I hereby release from liability the Society and its officers, directors, members, agents, and employees, and the providers of any information about me, and each of them, and agree to save and hold each of them harmless from and against all claims, costs and expenses (including reasonable attorneys' fees), demands, actions and liability arising from or relating to acts performed in good faith and without malice in connection with the provision, collection, or evaluation of the information or opinions, whether or not requested or solicited, concerning my application for membership in the Society.

I hereby represent and warrant that the information provided on this application for membership is accurate and complete. I agree that I will not cause or attempt to cause any public disclosure of the contents of any application for membership in the Society, including my own, or any proceedings of any committees evaluating such applications, whether disclosure is by operation of law or otherwise. Furthermore, I agree that if I am admitted as a member of the Society, I shall abide by the Bylaws and rules of the Society.

Signature of Applicant _____ Date _____

*All application materials including completed application, sponsor letter, and curriculum vitae are due by October 15.

Application materials should be sent to:

**Chair, Membership Committee • The Society of Thoracic Surgeons • 633 North Saint Clair Street, Suite 2320
Chicago, IL 60611 • (312) 202-5800 Phone • (312) 202-5801 Fax**