



# Florida Society of Thoracic and Cardiovascular Surgeons

## APPLICATION FOR MEMBERSHIP

Active \_\_\_\_\_ Associate \_\_\_\_\_

(Please Type or Print)

NAME \_\_\_\_\_ PHONE \_\_\_\_\_  
(Last) (First) (Middle)

OFFICE ADDRESS \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
(Street)

\_\_\_\_\_ FAX \_\_\_\_\_  
(City, State and Zip)

YOU MUST BE A RESIDENT OF THE STATE OF FLORIDA FOR AT LEAST TWO YEARS TO BECOME AN ACTIVE MEMBER OF THIS SOCIETY. IF NOT, YOU MAY APPLY FOR AN ASSOCIATE MEMBERSHIP.

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_ SPOUSE NAME \_\_\_\_\_

PREMEDICAL EDUCATION (with dates) \_\_\_\_\_

MEDICAL EDUCATION (with dates) \_\_\_\_\_

INTERNSHIP (with dates) \_\_\_\_\_

RESIDENCY / Other Graduate Training (with dates) \_\_\_\_\_

PRACTICE EXPERIENCE (since residency) \_\_\_\_\_

BOARD CERTIFICATIONS:	Date of Certificate	Certificate Number
American Board of Surgery	_____	_____
Board of Thoracic Surgery	_____	_____
Royal College of Surgeons	_____	_____
Other Professional Memberships:	_____	

Date licensed to practice in Florida (Must be at least 2 years for Active Membership): \_\_\_\_\_

List two FSTCS Members outside your own group who will provide references for this application:

(1) \_\_\_\_\_

(2) \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

PLEASE RETURN WITH \$50 APPLICATION FEE TO:

Florida Society of Thoracic and Cardiovascular Surgeons  
5101 Ortega Boulevard  
Jacksonville, Florida 32210  
(904) 683-8200 / FAX (904) 619-0642