Florida Society of Thoracic & Cardiovascular Surgeons

883 7th Avenue South ~ Jacksonville Beach, FL 32210
Phone 904-356-9300
www.fstcs.org ~ Shelly@fstcs.org

Qualifications for membership in the Florida Society of Thoracic & Cardiovascular Surgeons:

ACTIVE MEMBERSHIP- Annual dues $500 (Payable upon acceptance)

- Certification from the American Board of Thoracic Surgery
- Established in the practice of thoracic and cardiovascular surgery for a minimum of two (2) years in the state of Florida.
- Provide names of two FL licensed thoracic/cardiovascular surgeons **outside your own group practice** who will provide references for this application. ***One must be a current FSTCS Member**

ASSOCIATE MEMBERSHIP - Annual dues $450 (Payable upon acceptance)

- Have completed training in an approved thoracic and cardiovascular residency program
- Are in the process of acquiring certification
- Are licensed to practice in the State of Florida
- Provide names of two FL licensed thoracic/cardiovascular surgeons **outside your own group practice** who will provide references for this application. ***One must be a current FSTCS Member**

To apply for membership, simply complete and return the following:

1. **The attached Application for Membership**
2. **A copy of your CV and**
3. **The $50 application fee**

By Mail:

Florida Society of Thoracic & Cardiovascular Surgeons
883 7th Avenue South
Jacksonville Beach, Florida 32250

By email: Shelly@fstcs.org

$50 APPLICATION FEE						
METHOD OF PAYMENT:						
❑ Check Make payable to FSTCS	Check # _____	❑ AMEX	❑ MasterCard	❑ Visa		
Account #		Exp Date		CVV#		
Cardholder Name						
Cardholder Phone #						
Credit Card Billing Address						
City, State, Zip		State		Zip		
Signature						
E-mail address for receipt						

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APPLICATION FOR MEMBERSHIP ☐ Active Member ☐ Associate Member

Name:	Last:		First:		Middle:	

Practice Name:					
Office Address:		City:		Zip:	
Office Phone #:		Office Email:			
Home Address		City:		Zip:	
Cell Phone #:		Home E-Mail:			
Place of Birth:		Date of Birth:			
Spouse's Name:					

EDUCATION/EXPERIENCE	SCHOOL/LOCATION	DATES
Premedical Education		
Medical Education		
Internship		
Residency/Other Graduate		
Practice Experience (since residency)		
(attach additional sheet if necessary)		

BOARD CERTIFICATIONS	DATE OF CERTIFICATE	CERTIFICATE NUMBER
American Board of Surgery		
Board of Thoracic Surgery		
Royal College of Surgeons		
Other Professional Memberships (attach additional sheet if necessary)		

Date licensed to practice in Florida: (must be 2 years for Active Membership)		Medical License #:	

REFERENCES

List two Florida licensed thoracic/cardiovascular surgeons **outside your own group practice** who will provide references for this application.
***One must be a current FSTCS Member** (Membership list available upon request)

1. Name:		Email:	
2. Name:		Email:	
Signature:		Date:	