

**Eligibility**—Associate membership is available to non-surgeon physicians who have a demonstrated active interest in the field of vascular disease, scientists at the doctoral level conducting vascular research, and doctors of podiatric medicine. For this category, the following criteria will be considered in evaluating applicants:

- Certification in the applicant’s own specialty
- Letters of support from Society for Vascular Surgery members
- Clinical contributions to vascular practice
- Contributions to vascular education and research
- Participation in national societies in the applicant’s chosen specialty

## IDENTIFYING INFORMATION

FIRST NAME	<input type="text"/>
MIDDLE NAME	<input type="text"/>
LAST NAME	<input type="text"/>
SUFFIX (e.g., MD)	<input type="text"/>

### BUSINESS ADDRESS

INSTITUTE	<input type="text"/>
ADDRESS 1	<input type="text"/>
ADDRESS 2	<input type="text"/>
CITY, STATE, ZIP	<input type="text"/>
BUSINESS PHONE	<input type="text"/>
BUSINESS FAX	<input type="text"/>
EMAIL	<input type="text"/>

### HOME ADDRESS

ADDRESS 1	<input type="text"/>
ADDRESS 2	<input type="text"/>
CITY, STATE, ZIP	<input type="text"/>
HOME PHONE	<input type="text"/>
EMAIL	<input type="text"/>

## PRACTICE INFORMATION

PRACTICE INFORMATION  
BEGIN DATE (MM/YYYY)   /

PRACTICE LIMITED TO

WHAT PERCENTAGE OF YOUR PRACTICE IS DEVOTED  
TO THE TREATMENT OF VASCULAR DISEASE?  %

## PROFESSIONAL ACTIVITIES

Do you have hospital privileges?  YES  NO

If yes, please complete the following:

HOSPITAL  
NAME

BEGIN DATE (MM/YYYY)   /     END DATE (MM/YYYY)   /      
OR  
CURRENT

## CURRENT MEDICAL SCHOOL APPOINTMENTS

SCHOOL  
NAME

POSITION

BEGIN DATE (MM/YYYY)   /     END DATE (MM/YYYY)   /      
OR  
CURRENT

## SOCIETY MEMBERSHIPS

Please list your membership in any medical societies and the date your joined:

SOCIETY 1  DATE JOINED (MM/YYYY)   /

SOCIETY 2  DATE JOINED (MM/YYYY)   /

SOCIETY 3  DATE JOINED (MM/YYYY)   /

## POSTGRADUATE TRAINING

Internships, residency, or approved vascular residency

TYPE

LOCATION

INTERNSHIP  
TYPE

RESIDENCY  
TYPE

PROGRAM  
DIRECTOR

BEGIN DATES (MM/YYYY)   /     END DATES (MM/YYYY)   /

## LETTERS OF SUPPORT

Two letters from physicians are required, one of which must be from an active SVS member; no more than one can be from someone with whom you have a financial relationship. The letters must comment on your commitment to, and practice of, vascular surgery. Letters of support should be obtained from your sponsors and must be written on their institution's letterhead. The appropriate file formats are Word or PDF files. Letters of support must be attached to this application and emailed to **membership@vascularsociety.org**.

Supplemental documents include:

- Presentations
- Publications
- Research grants

SPONSOR 1 NAME

SPONSOR 2 NAME

## Section Memberships

*If desired, please check the box(es) next to the SVS Sections you wish to join.*

Section on Outpatient and Office Vascular Care

## APPLICATION PAYMENT

**You will be invoiced the non-refundable \$100 application upon processing of your application. This invoice will be payable online with your credit card and you will receive a receipt when your payment has been processed.**

Membership applications are now reviewed on a quarterly basis. Deadlines are on the first of the month in March, June, September and December.

## Statement of Authorization

I hereby apply for membership in the Society for Vascular Surgery, and certify that the statements contained in this application and its attached documents are true to the best of my knowledge and belief and further acknowledge that falsification is cause for disqualification of my application. I hereby grant permission to the Society to make inquiries it deems necessary of the hospitals where I practice to confirm these statements. I further understand and agree that in consideration of my application my ethical and professional standing will be reviewed and assessed by the Society, that the Society may make inquiry of the persons and institutions, including any medical organizations of which I am a member, named in my application and of such other persona as the Society deems appropriate. I understand I will not be advised of the identity of the persons from whom information has been requested or as to the nature of such information; and that all statements and other information furnished to the Society in connection with such inquiry shall be confidential. If my application is accepted, I pledge to abide by the Society's Bylaws, Code of Ethics and its policies and procedures. I hereby agree that if my application is not acted upon favorably, I will not hold the Society or any of its officers, members, or agents legally responsible for such action. The above representations are accurate and complete to the best of my knowledge and belief.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_