

1. I hereby make application for (circle one) **ACTIVE AFFILIATE RESIDENT RETIRED** membership

2. Name: \_\_\_\_\_ 3. Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle) (Month) (Day) (Year)

4. **Home Address:** \_\_\_\_\_ Is this your primary mailing address?  Yes  No

\_\_\_\_\_  
(Number) (Street)  
 \_\_\_\_\_  
(City) (State) (Zip Code) (Country)

**Business Address:** \_\_\_\_\_ Is this your primary mailing address?  Yes  No

\_\_\_\_\_  
(Company Name) (Department)  
 \_\_\_\_\_  
(Number) (Street)  
 \_\_\_\_\_  
(City) (State) (Zip Code)

**Billing Address for ASA Dues Statement:** If not completed, statement will be sent to Primary Mailing Address

\_\_\_\_\_  
(Company Name – if applicable) (Department – if applicable)  
 \_\_\_\_\_  
(Number) (Street)  
 \_\_\_\_\_  
(City) (State) (Zip Code)

Office Telephone\* \_\_\_\_\_  Do Not Display

Office Fax Number\* \_\_\_\_\_  Do Not Display

E-Mail Address\* \_\_\_\_\_  Do Not Display

5. Location of Principal Professional activity: \_\_\_\_\_ 6. Gender:  M  F

7. Medical Education: \_\_\_\_\_  
(School) (City) (State) (Country) (Years) (Degree)

8. Internship: \_\_\_\_\_ 9. Residency: \_\_\_\_\_  
(Location and Dates) (Location and Dates)

10. Licensed to practice in: \_\_\_\_\_, \_\_\_\_\_  
(State and Date) (State and Date)

11. Previous membership in ASA or Component Society: \_\_\_\_\_  
(Society and Dates)

12. Certification by: ABA \_\_\_\_\_ Other \_\_\_\_\_  
(Date) (Number) (Date) (Number)

13. Present Appointments: \_\_\_\_\_  
(Indicate Institutions and Dates)

14. \_\_\_\_\_  
**(APPLICANT'S SIGNATURE)**

\*Unless indicated in the "Do Not Display" box, this information will be included in your computer listing that can be viewed by other ASA members.

**Note: Resident and Affiliate applicants continue on back of form.**

**FOR PHYSICIAN IN FULL-TIME TRAINING**

15. Present full-time training: \_\_\_\_\_  
(Hospital)

\_\_\_\_\_  
(City) (State) (Date Begun) (Proposed Termination Date)

\_\_\_\_\_  
(Program Director – Please Print) (Program Director Signature)

**Note: For Resident Applications only, dues of \$25.00 must accompany application; \$12.50 after June 30.**

**SPONSORS**

16. ACTIVE membership – ASA does not require sponsor signatures. (Component membership required)\*  
AFFILIATE membership – Sponsors (Two Active or Affiliate members) required only for applicants who are not members of a component society.\*

\_\_\_\_\_  
(Printed Name) (City and State) (Signature)

\_\_\_\_\_  
(Printed Name) (City and State) (Signature)

\*ASA does not require sponsor signatures for applicants who will become members of a component society. However, it is recommended that sponsor signatures be included because, in most instances, this application will also be used for component society membership, which usually requires sponsor signatures.

**FOR PHYSICIAN IN FULL-TIME MILITARY SERVICE**

17. \_\_\_\_\_  
(Rank) (Duty Station) (Branch)

**TO BE COMPLETED BY COMPONENT SOCIETY SECRETARY**

Approved as a(n) \_\_\_\_\_ member in good standing of the \_\_\_\_\_  
(Category) (Component)

Society of Anesthesiologists.

\_\_\_\_\_  
(Date) (Secretary of Component Society)

COMMENTS:

**FOR ASA USE ONLY**

Elected to \_\_\_\_\_ membership on \_\_\_\_\_  
(Category) (Date)

Membership No. \_\_\_\_\_

COMMENTS: