

# Physician Application For Membership



AMERICAN SOCIETY  
FOR MOHS SURGERY

6475 East Pacific Coast Highway, #700  
Long Beach, CA 90803-4201  
Phone: (800) 616-ASMS (2767) (714) 379-6262  
Fax: (714) 362-9540

Referral Source:  Colleague  Attended a Meeting  Residency Program  Other: \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Practice Name and Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Office Fax \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Web Address \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ CC E-mail \_\_\_\_\_

Mailing address preference:  Practice  Home

## Education

Medical School \_\_\_\_\_ Year Began \_\_\_\_\_ Ended \_\_\_\_\_

Internship \_\_\_\_\_ Year Began \_\_\_\_\_ Ended \_\_\_\_\_

Dermatology Residency \_\_\_\_\_ Year Began \_\_\_\_\_ Ended \_\_\_\_\_

(International Applicants Only)  
Non-Dermatology Residency \_\_\_\_\_ Year Began \_\_\_\_\_ Ended \_\_\_\_\_

Post Graduate Training \_\_\_\_\_ Total Years \_\_\_\_\_

## Professional Credentials

### (U.S. Applicants only)

Dermatology or Pathology Board Certification:  Yes Specialty \_\_\_\_\_ Date \_\_\_\_\_  No

*U.S. dermatologist applicants for Affiliate or Fellow membership must attach proof of board certification by either the American Board of Dermatology or the American Osteopathic Board of Dermatology, or their international equivalents. Similarly, U.S. pathologist applicants for Affiliate membership must provide certification by the American Board of Pathology, or their international equivalents. Dermatologist applicants for Associate membership must provide proof of completed ACGME accredited or AOA-approved dermatology residency training. A current CV is required for each applicant.*

### (International Applicants only)

Dermatology or Non-Dermatology Board Certification:

*International dermatologist and non-dermatologist applicants for International or International Member of Distinction membership must attach proof of board certification in their medical specialty. A current CV is required for each applicant.*

Yes Specialty \_\_\_\_\_ Date \_\_\_\_\_  No

## Medical License Number(s):

\_\_\_\_\_ Date \_\_\_\_\_ State/Country \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ State/Country \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_ State/Country \_\_\_\_\_

**Please Indicate Appropriate Membership Category**

**U.S.**

Fellow Member (Each candidate must apply initially as an Affiliate member before upgrading to Fellow member)

- Affiliate Member (Dermatologist or Pathologist)
- Member
- Resident Member

**International**

International Member of Distinction  
(Each candidate must apply initially as an International Affiliate before upgrading to International Member of Distinction)

- International Affiliate Member
- International Resident Member

*Please describe your training in Mohs surgery: (Attach separate sheet if necessary)*

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**Additional Professional Data**

Full-Time/Part-Time Academic Affiliation(s): \_\_\_\_\_

Hospital Appointments: \_\_\_\_\_

Publications & Exhibits: \_\_\_\_\_

Membership in Other Professional Societies: \_\_\_\_\_

Areas of Research: \_\_\_\_\_

**If the answer to any of the following questions is "yes", please indicate complete details on a separate sheet:**

- A. Has your license to practice medicine in any jurisdiction ever been limited, Suspended, or revoked?  Yes  No
- B. Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed?  Yes  No
- C. Have you ever been dismissed or resigned from a previous hospital medical staff?  Yes  No
- D. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any local, state, or national medical society?  Yes  No
- E. Are you currently performing Mohs Surgery in your practice?  Yes  No

- Yes- I am including a copy of my Board Certification and CV.**
- N/A- Doesn't apply to the category of membership.**

**Payment Information:** \$400 – Application fee and first year of membership dues

Check Enclosed (U.S. Funds, Payable to ASMS)  VISA/MasterCard/American Express/Discover Total \_\_\_\_\_

**Credit Card#** \_\_\_\_\_ **Expiration Date** \_\_\_\_\_ **3 or 4-digit Verification Code** \_\_\_\_\_

**Name on Card** \_\_\_\_\_

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