

**SOUTHEASTERN  
SURGICAL  
CONGRESS**



**APPLICATION FOR FELLOWSHIP**

**INSTRUCTIONS ON LAST PAGE**

# APPLICATION FOR FELLOWSHIP

(All areas must be completed fully and CV attached before application will be accepted)

Check One:  Regular  Affiliate  Resident

Please print or type

Name \_\_\_\_\_  
(First) (Middle) (Last)

**Address** (Please fill in **BOTH** professional and residence information, then check primary address to which all official correspondence should be sent)

Professional \_\_\_\_\_

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

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail \_\_\_\_\_

Residence \_\_\_\_\_

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

Telephone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail \_\_\_\_\_

Birthdate \_\_\_\_\_ Place \_\_\_\_\_

## **EDUCATION AND TRAINING:**

Please attach a current Curriculum Vitae. This CV should include information on undergraduate, post-graduate, medical, internships, residency, and fellowship education along with surgical organizations memberships, hospital and teaching affiliations, and bibliography.

## **BOARD CERTIFICATION:**

Specialty \_\_\_\_\_

Year training completed \_\_\_\_\_

Year most recent ABMS Board Certification Completed \_\_\_\_\_

Certificate Number \_\_\_\_\_

Re-Certification Date \_\_\_\_\_

If not ABMS Board certified, are you registered with the ABS for pursuit of certification? \_\_\_\_\_

**REFERENCES:**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Address \_\_\_\_\_

**If accepted for Fellowship, I hereby agree to abide by the Constitution and By-Laws of the Southeastern Surgical Congress, to attend its meetings, and contribute by the presentation of papers and entering into discussions.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Applicant, do not write below this line*

**Approved by State Councilor**

Fellow Yes \_\_\_\_\_ No \_\_\_\_\_

Affiliate Fellow Yes \_\_\_\_\_ No \_\_\_\_\_

Resident Member Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
**Signature of State Councilor**

\_\_\_\_\_  
**Date**

**Approved by Membership Committee**

\_\_\_\_\_  
**Chairman, Membership Committee**

\_\_\_\_\_  
**Date**

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

Date \_\_\_\_\_

 **Fellow**

 **Affiliate Fellow**

 **Resident Member**

# **SOUTHEASTERN SURGICAL CONGRESS**

## **CATEGORIES OF FELLOWSHIP**

- FELLOW** A surgeon who is a diplomate of an approved surgical board\*
- AFFILIATE FELLOW** A surgeon who has completed and approved residency\*\* but has not passed the respective board exams. Dues shall be the same as for Fellow.
- RESIDENT MEMBER** A resident who is in training in an approved residency.\*\*

All members receive a subscription to THE AMERICAN SURGEON.

\* Approved by the American Board of Medical Specialties

\*\* Approved by the Accreditation Council for Graduate Medical Education

## **INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR FELLOWSHIP**

1. Applications for Fellowship must include three references
2. All information must be filled in completely.
3. Completed application should be mailed to: Southeastern Surgical Congress  
115 Samaritan Drive, #200  
Cumming, GA 30040