



APPLICATION FOR MEMBERSHIP

Fax or Mail To:
FSGS
6816 Southpoint Parkway, #1000
Jacksonville, FL 32216
T: 904-309-6270 F: 904-998-0855

Date _____

Name _____ Title _____

Date of Birth _____ Male _____ Female _____ Email _____

Mailing Address _____

City _____ State _____ Zip _____

Office Ph _____ Office Fax _____ Home Ph _____

Send Mail to: [] Office [] Home

Medical School _____ Year _____

Residencies _____ Years _____
_____ Years _____
_____ Years _____

Certified American Board of Surgery _____ Date _____

American College of Surgeons Fellowship # _____ Date _____

Certified by other Specialty Board (Specify which date) _____

Hospital Appointments _____

Member of County Medical Society (Name) _____

List Memberships in other National or State Medical Professional Societies _____

Are you applying for Active Membership ___ Resident/In-Training Membership ___
(To see the membership requirements please refer to the Constitution and Bylaws)

Are you a member of the Florida Medical Association ___ No ___ Yes

The name of the Person who referred you _____

Active members must meet the following criteria;
degreed MD or DO from an accredited medical
school, certified by the American Board of Surgery
and whose practices are limited to general surgery.

Junior members must meet the following criteria:
degreed MD or DO who is serving in a full-time board
certified training program specific to General Surgery
(documentation from chairperson must accompany
this application). Within three years of achieving
board certification, this membership shall be
converted to an Active status.

Membership Dues
Active Member & Application Fee....\$250.00
Junior or In-Training Membership..... \$0.00
Method of Payment
[] Check [] Visa [] MC [] AMEX
Amount: _____ Exp. Date: _____
Account # _____
Name on Card _____
Signature: _____

Signature _____