(Please print or type)

Affiliate Member Information

Name:______________________________ Date:______________
(Full Legal Name)

Date of Birth:______________ Gender: ❑ Male ❑ Female

Home Address:______________________________ Is this your primary address: ❑ Yes ❑ No

City:______________ State:__________ ZIP: ________ Country: ____________

Business Address:______________________________ Is this your primary address: ❑ Yes ❑ No

Company Name:______________________________ Department: ______________

City:______________ State:__________ ZIP: ________ Country: ____________

*Email:______________________________ ❑ Do Not Display

*Tel:______________________________ ❑ Do Not Display *Fax:______________ ❑ Do Not Display

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

State of Principal Professional acitivity (e.g., Florida): ______________________________

Medical School: ______________________________

Medical School Address: ______________________________ Suite No: ______________

City:______________ State:__________ ZIP: ________ Country: ____________

Years: __________ Degree: ______________________________

Internship: ______________________________ Residency: ______________________________
(Location and Dates) *(Location and Dates)*

Licensed to practice in: ______________________ Licensed to practice in: ______________________
(State and Date) *(State and Date)*

Certification by: ABA: ______________________ Other Certification: ______________________
(Date and ABA I.D. Number) *(Date and Number)*

Present Appointments: ______________________________
(Indicate Institutions and Dates)

Applicant's Signature: ______________________________ **Date:** ______________

Payment Method

❑ Option A – Membership WITHOUT print copies of *Anesthesiology* (includes online access). Dues of $352 must accompany application; $176 after July 31.

❑ Option A – Membership WITH print copies of *Anesthesiology.* Please include the mailing fee: $65. Total of $417 must accompany application; $241 after July 31.

❑ American Express ❑ MasterCard ❑ VISA

Total Amount:________________________Name on Card:____

Credit Card Number:_______________________________________ Expiration Date:__________Card ID:___________________

Signature:____

If paying by credit card, your card will be charged upon approval of your application.

The credit card number you supplied on this application may also be used to charge your component society dues, if the component accepts credit cards and charges dues. This will be a separate transaction on your statement. Those components that do not accept credit card payments and charges dues will contact you for payment of component dues. Please contact ASA Member Services at (847) 825-5586 with any questions. ***Dues are based on the calendar year.***

Membership in good standing of the American Society of Anesthesiologists requires adherence to the ASA "Guidelines for the Ethical Practice of Anesthesiology."

Mail payment and completed form to:
American Society of Anesthesiologists
Attn: Membership
1061 American Lane
Schaumburg, IL 60173-4973

Or fax to:
Attn: Membership (847) 825-1692

TO BE COMPLETED BY COMPONENT SOCIETY SECRETARY

Approved as a(n) ____member in good standing of the
(Category)

____ Society of Anesthesiologists.
(Component)

______________________________ ____
(Date) (Secretary of Component Society)

American Society of Anesthesiologists
1061 American Lane
Schaumburg, IL 60173-4973
asahq.org