

# INTERNATIONAL COLLEGE of SURGEONS • UNITED STATES SECTION

1516 NORTH LAKE SHORE DRIVE • CHICAGO, Illinois 60610-1694

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FOUNDED IN GENEVA, SWITZERLAND IN 1935. INCORPORATED IN WASHINGTON, DC, IN 1940.

First Name \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_  MD  DO

Office Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Work Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

Specialty **PRIMARY** \_\_\_\_\_ **SECONDARY** \_\_\_\_\_

Date of Birth **MONTH** \_\_\_\_\_ **DAY** \_\_\_\_\_ **YEAR** \_\_\_\_\_ Sex {M or F} Citizenship \_\_\_\_\_

Spouse's First Name \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_

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

City, State, Zip Code \_\_\_\_\_

Industry Positions \_\_\_\_\_

## REFERENCES

Please list three (3) surgeons familiar with your work. References will preferably be provided by the Chair of the Surgical Department in which you work, a surgical colleague who works in your hospital or a Fellow in good standing with the ICS. All information received will be treated with the utmost regard for confidentiality.

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone \_\_\_\_\_

## SPONSOR INFORMATION

(if recommended by a current ICS Fellow)

Name \_\_\_\_\_

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

## FOR OFFICE USE ONLY

DOI: \_\_\_\_\_

DisRqst \_\_\_\_\_

Application Fee: \$325.00

Check Enclosed  Visa/MasterCard  AMEX

Cardholder Name \_\_\_\_\_

Card Number \_\_\_\_\_

Expiration \_\_\_\_\_

Authorized Signature \_\_\_\_\_

## Submission of CURRICULUM VITAE

Please mail a current copy of your Curriculum Vitae along with a completed Application for Fellowship, and ensure that it contains the following information:

- Name and location of medical school you attended
- Date of graduation from medical school
- Number of years of postgraduate training
- Residency training
- Medical license(s) held & Board certification(s) held

## AUTHORIZATION TO RELEASE

Recognizing that an investigation of my qualifications is necessary prior to becoming a member of the ICS, I hereby authorize said College, its Qualifications and Interim Council, officers, agents, employees and representatives to seek any and all documents at their discretion to evaluate this application for membership.

I hereby authorize all persons, firms, corporations - including and without limitation hospitals, medical associations and physicians - to divulge to the ICS any information, letters, or written material relating in any manner to my professional qualifications, clinical competency, character or any other matter that is directly or indirectly related to this application. With respect to any disclosures, discussions, reports, communications, and the evaluations made herewith, I do hereby release the ICS, its Qualifications and Interim Council, officers, agents, employees and representatives and any other persons, firms, corporations, hospitals or individuals delivering any information or written material to any of them from any and all civil liability as a result of any actions or inactions by any of them as a result thereof. 13/05

Signature of Applicant \_\_\_\_\_