



Complete and mail with dues check for \$150 to:

GA Society of Plastic Surgeons

114 Cherry Street, Suite D

Marietta, GA 30060

exec@gspss.info or Fax 770-427-2711

Application for Membership

Name _____ Birth _____ / _____ / _____

Social Security _____ Spouse _____

Office Address _____

Group Name

Street Address

Suite Number

City

State

Zip

Telephone

Fax

Home Address _____

Street Address

City

State

Zip

Telephone

Cell or Pager

Email Address _____ @ _____

Specialty _____

Primary

Secondary

Board Certification _____ GA License # _____

Medical School _____

Attended _____

Name

City

ST

I am a member in good standing in ASAPS or ASPS Yes No

ASPS Member # _____

If you are not a member in good standing with ASAPS or ASPS please complete the second page.

The undersigned applicant:

hereby certifies that all of the information contained in the application is true and correct; hereby authorizes the Georgia Society of Plastic Surgeons, and its authorized representatives to consult with any and all persons and obtain any and all documents necessary to verify the accuracy of the information contained in this application; hereby releases the Georgia Society of Plastic Surgeons, and its authorized representatives and all persons and organizations who provide information to the Georgia Society of Plastic Surgeons or its authorized representatives in accordance with this application from any liability arising out of the above described authorization actions; hereby agrees to promptly notify the Georgia Society of Plastic Surgeons, in writing, in the event of a material change in any of the information provided by the Applicant in this application.

This _____ day of _____ 2015

Applicant Signature

Application continued on other side

Present Hospital
Staff Privileges

Hospital

Type

Active, Associate, Courtesy, etc.

_____	_____
_____	_____
_____	_____
_____	_____

Residences,
Internships &
Fellowships:

Name

Date

_____	_____
_____	_____
_____	_____

Disciplinary actions taken against Applicant by hospitals at which Applicant presently has staff privileges
(please describe)

Disciplinary action taken against Applicant by other hospital(s) at which Applicant had staff privileges (please describe)

Disciplinary actions taken against Applicant by Composite State Board of Medical Examiners or other licensing body (please describe)

Any drug or alcohol abuse, past or present? (please describe)
