ACS Member Services American College of Surgeons

# Resident Membership
## ENROLLMENT FORM

Institution: _____

Address: _____

City/State/ZIP: _____

Program Director Name: _____

Program Coordinator Name: _____

Program Coordinator Phone: _____ E-mail: _____

Enrollment is for (select one): ☐ Current Academic Year ☐ Next Academic Year

| Name (Last, First) | Gender | DOB | Mailing Address<br>If different from program address above | E-mail Address<br>Personal or institutional address<br>(cannot accept coordinator e-mail addresses) | PGY | Medical School | Medical Degree | Graduation Year | Specialty |
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*Note: If more space is needed, please include a second application form.*

☐ This list serves as verification that each resident/fellow/researcher is in good standing at our institution

☐ I am requesting an invoice to remit the $20 (per resident) application fee; PGY-1s have their application fee waived

Program Coordinator Signature: _____ Today's Date: _____

**2 EASY WAYS** to submit your form

**E-MAIL**
enroll@facs.org

**FAX**
312-202-5007
*Attention: Cory Suzan Petty*

American College of Surgeons
633 N. Saint Clair Street, Chicago, IL 60611-3211
***facs.org***

ACS Member Services American College of Surgeons

# Medical Student
## ENROLLMENT FORM

Academic Year: _____

Clerkship Director Name: _____

Institution: _____

Address: _____

City/State/ZIP: _____

Clerkship Director Phone: _____ E-mail: _____

| Name (Last, First) | Gender | DOB | Mailing Address If different from program address above | E-mail Address | Medical School Start Date | Anticipated Graduation Date |
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*Note: If more space is needed, please include a second application form.*

☐ This list serves as verification that each student is in good standing at our institution

☐ I am requesting an invoice to remit the $20 (per student) application fee

Clerkship Director: _____ Today's Date: _____

**2 EASY WAYS** to submit your form

**E-MAIL**
enroll@facs.org

**FAX**
312-202-5007
*Attention: Cory Suzan Petty*

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