MEMBERSHIP APPLICATION FORM

Name: ____
Practice Name: ____
Business Address: ____
City, State Zip: ____
Phone: _____________________________ Fax: _____________________________
E-Mail: ____

Office Manager: ____
Office Manager Email: ____
Home Address: ____
Home Phone: ________________________Date of Birth: ____________________

MD/DO Degree from: ____
CT License Number: ____
Year Obtained: ____

Sponsor's Name: ____
Sponsor's Address: ____
Sponsor's Phone: ____

Residency Training: ____
Mo/Yr Began: __________________ Mo/Yr Completed: ____________________

For information only, not a condition of membership
ABOS Board Certified? __Yes __No
Member of AAOS? __Yes __No

THIS SECTION TO BE COMPLETED BY RESIDENT/FELLOW APPLICANTS ONLY

Name: ____
Address: ____
Institution: ____
Projected Graduation Date: ____
Program Chair: ____
Program Chair Signature: ____

Make checks payable in the amount of $250.00 to **Connecticut Orthopedic Society** Payment should accompany this application and be mailed to:

Susan Schaffman, Executive Director,
CT Orthopedic Society
26 Riggs Avenue
West Hartford, CT 06107

PAYING BY CREDIT CARD

Please charge my credit card in the amount of $250.00 annually for membership dues in the Connecticut Orthopaedic Society.

Mastercard or Visa (circle one)

Name on Account ____
Account Number ____
Expiration Date ____
___ Yes, charge my credit card each year (January) for the membership dues until I notify otherwise.
___ No, do not charge my credit card each year. I will issue a new credit card authorization each year.

Signature ____

For additional information and questions, please call Susan Schaffman at (860) 561-5205, fax (860)561-5514 or email sasshops@aol.com. Thank you.