2020 MEMBERSHIP APPLICATION
GENERAL MEMBERSHIP

Florida Society of Dermatologic Surgeons
445 Fort Drum Court
Saint Augustine, FL 32092
P: (904) 292-0051
F: (888) 492-4116
fsds@fsds.org

APPLICANT INFORMATION

Title _____ Name _____

Date of Birth ____ / ____ / _____ ☐ Male ☐ Female License Number _____

Office Address _____

City _____ State _____ Zip _____

Email _____ Office Fax _____

Office Phone _____ Cell Phone _____

INFORMATION FOR MEMBERSHIP

FSDS Member Reference _____
(please provide the name of an active FSDS member who can provide a recommendation for membership on your behalf)

University / Hospital Affiliations _____

Medical Society Memberships ☐ AAD ☐ ASDS ☐ FMA ☐ FSDDS ☐ OTHER _____

If you answer "yes" to any of the following give questions, please provide an explanation and records if available

1.	Have you ever received an official censure or reprimand from a medical society?	☐ Yes	☐ No
2.	Are you now or have you ever been party to malpractice litigation?	☐ Yes	☐ No
3.	Have you ever been convicted of a crime?	☐ Yes	☐ No
4.	Have you ever been subject to discipline by a medical or health care regulatory board or agency?	☐ Yes	☐ No
5.	Have you ever been subject to discipline by a hospital or healthcare organization?	☐ Yes	☐ No

SUBMITTING OF APPLICATION

All documents may be submitted via email, fax, or mail to the FSDS Executive Office (listed above). Please refer to the FSDS bylaws for further details and descriptions.

☐ **Application Fee ($75.00)**

☐ **Annual Dues ($295.00)**

☐ **Letter of Recommendation**
(must be from a current FSDS member)

Payment can be made via:
- **Credit Card** - complete payment information
- **Check** - made out to FSDS, and mailed to the FSDS office (address on top right of application)

PAYMENT BY CREDIT CARD

Amount to be Charged _____
Credit/Debit Card # _____
Exp. Date _____ / _____ CVV _____
Billing Address _____
City _____ State _____ Zip _____
Cardholder's Name _____
Cardholder's Signature _____

I affirm that the information submitted is true and correct to the best of my knowledge. I hereby authorize the Florida Society of Dermatologic Surgeons to obtain verification of any of the information listed above.

_____ _____
Signature of Applicant Date