

# SPINE INTERVENTION SOCIETY FELLOW/RESIDENT/MEDICAL STUDENT MEMBERSHIP APPLICATION



## PERSONAL & CONTACT INFORMATION

Name: First/Middle/Last \_\_\_\_\_

Nickname \_\_\_\_\_

Degree(s) \_\_\_\_\_

Specialty \_\_\_\_\_

Date of Birth \_\_\_\_\_

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

Home City/State/Province/Postal Code/Country \_\_\_\_\_

Program/School-based Email \_\_\_\_\_

Status  
Fellow    Resident    Medical Student

Gender  
Female    Male    additional gender category/identity:  
please specify \_\_\_\_\_  
prefer not to respond

Preferred Primary Email    Program    Personal  
Preferred Mailing Address    Program    Personal

Personal/Permanent Email \_\_\_\_\_

Program/School Phone \_\_\_\_\_

Personal Phone \_\_\_\_\_

Facebook Profile URL \_\_\_\_\_

LinkedIn Profile URL \_\_\_\_\_

Twitter Handle \_\_\_\_\_

## QUALIFICATIONS

Membership is limited to those ultimately pursuing certification in the following specialties:

I am currently certified in one or more of the following specialties, and have attached verifying documentation.

I am not currently certified in one of the following specialties, but I expect to complete certification on \_\_\_\_\_, and have attached verifying documentation.

I am not currently certified, but I affirm my intention to pursue certification in one of the following specialties.

ANESTHESIOLOGY

NEUROLOGY

NEUROSURGERY

ORTHOPEDIC SURGERY

PHYSICAL MEDICINE  
AND REHABILITATION

RADIOLOGY

## PROGRAM/SCHOOL INFORMATION

Program/School Name \_\_\_\_\_

Program/School Street Address \_\_\_\_\_

Program/School City/State/Province/Postal Code/Country \_\_\_\_\_

Expected Med School Graduation or Current Program Completion \_\_\_\_\_

If in Fellowship list Residency program and completion date \_\_\_\_\_

Current Residency or Fellowship Program Director \_\_\_\_\_

Current Residency or Fellowship Program Director Email \_\_\_\_\_

Current Residency or Fellowship Program Director Phone \_\_\_\_\_

Current Residency or Fellowship Program Coordinator \_\_\_\_\_

Current Residency or Fellowship Program Coordinator Email \_\_\_\_\_

Current Residency or Fellowship Program Coordinator Phone \_\_\_\_\_

## APPLICATION REQUIREMENTS Please indicate that you have attached all required verifying documents.

Curriculum Vitae    Program/School Acceptance Letter    For Fellows and Residents - documentation of certification, or verification of exam scheduling

## AUTHORIZATION

I hereby release from liability all representatives of the Spine Intervention Society in connection with evaluating my application, credentials, and qualifications. By signing this application I affirm that the provided information is true.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### PLEASE MAIL, EMAIL, OR FAX COMPLETED APPLICATION TO:

Spine Intervention Society - Membership Department  
120 E. Ogden Ave. Ste. 202 | Hinsdale, Illinois 60521  
membership@SpineIntervention.org | fax 415.457.3495 | phone 630.203.2252 | U.S. toll free 888.255.0005