RHODE ISLAND ORTHOPEDIC SOCIETY
MEMBERSHIP APPLICATION

Name _____
(last) (first) (middle)

Business Address _____
(street) (city) (state) (zip code)

Business Phone _____ Business Fax _____
(area code) (area code)

E-mail _____

Home Address _____
(street) (city) (state) (zip code)

Home Phone _____ Email _____
(area code)

Date of Birth _____ Place of Birth _____

Date Began Practice _____

What undergraduate college or colleges did you attend? Give dates.

_____

_____

What medical college did you attend? Give dates.

_____

_____

In what hospital did you serve as:

Intern _____

_____ From _____ To _____

Resident _____

_____ From _____ To _____

Assistant _____

_____ From _____ To _____

What Post-graduate studies have you pursued, where and when:

_____

_____ From _____ To _____

_____

_____ From _____ To _____

In what hospitals are you a staff member and/or have teaching appointments?

____ Position ___________________________

____ Position ___________________________

____ Position ___________________________

Are you a member of:

The American Medical Association __________ The American College of Surgeons ___________

Date of Membership in the American Academy of Orthopaedic Surgeons ___________________________

Date certified by the American Board of Orthopaedic Surgeons ___________________________________

Of what other medical societies are you a member?

____

____

Have you ever applied to any medical organization and been refused?

____

____

To the best of your knowledge is there any professional or personal problem which would disqualify you from membership:____

____

Your signature: ____ Date: __________________

Please mail this completed application with your membership dues check of $350 to:

Rhode Island Orthopedic Society

Attn: Megan Turcotte

405 Promenade Street, Suite A

Providence, RI 02908

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Action: Applicant notified of approval

Membership Chairman ____ Date _____________________