



# NEW YORK REGIONAL SOCIETY OF PLASTIC SURGEONS

## APPLICATION FOR RESIDENT MEMBERSHIP

Date: \_\_\_\_\_

I hereby make application for Resident Membership in the New York Regional Society of Plastic Surgeons.

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Birthdate: \_\_\_\_\_

Hospital \_\_\_\_\_  
Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Home \_\_\_\_\_  
Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Paramedical education (include dates attended & degree(s) obtained):

\_\_\_\_\_  
\_\_\_\_\_

Medical education (include dates attended & degree(s) obtained):

\_\_\_\_\_  
\_\_\_\_\_

Residency training (include hospital, type and dates attended, in chronological order):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical License (include state, number & date obtained):

\_\_\_\_\_  
\_\_\_\_\_

Certification by American Boards (include Name of Board & date):

\_\_\_\_\_  
\_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

### PLASTIC SURGERY RESIDENCY PROGRAM DIRECTOR CERTIFICATION:

I hereby confirm that the applicant is a plastic surgery resident in good standing and support his/her application for Resident membership of NYRSPS.

Name of Director: \_\_\_\_\_ Signature & Date: \_\_\_\_\_

Name of Residency Program: \_\_\_\_\_

Return application to: NYRSPS, P.O. Box 3191, Grand Central Station, New York, N.Y. 10163

Phone/Fax: 212-620-5653