ACS Member Services American College of Surgeons

Resident Membership
ENROLLMENT FORM

Institution: _____

Address: _____

City/State/ZIP: _____

Program Director Name: _____

Program Coordinator Name: _____

Program Coordinator Phone: _____ E-mail: _____

Enrollment is for (select one): Current Academic Year Next Academic Year

Name (Last, First)	Gender	DOB	Mailing Address	E-mail Address	PGY	Medical School	Medical Degree	Graduation Year	Specialty

Note: If more space is needed, please include a second application form.

This list serves as verification that each resident/fellow/researcher is in good standing at our institution

I am requesting an invoice to remit the $20 (per resident) application fee; PGY-1s have their application fee waived

Program Coordinator Signature: _____ Today's Date: _____

2 EASY WAYS to submit your form

E-MAIL
enroll@facs.org

FAX
312-202-5007
Attention: Cory Suzan Petty

American College of Surgeons
633 N. Saint Clair Street, Chicago, IL 60611-3211
facs.org

Member Services

American College of Surgeons

Academic Year: _____

Clerkship Director Name: _____

Institution: _____

Address: _____

City/State/ZIP: _____

Clerkship Director Phone: _____ E-mail: _____

This list serves as verification that each student is in good standing at our institution

I am requesting an invoice to remit the $20 (per student) application fee

Clerkship Director: _____

Today's Date: _____