CSPS MEMBERSHIP APPLICATION

Name: ______________________________ Medical Lic. #______________ DOB:____________

Business Address: ____
Street City State Zip

Business Phone: ________________ FAX: ________________ Email: ________________

Home Address: ____
Street City State Zip

Home Phone: ________________ Spouse Name (if applicable): __________ Voting District: __________

EDUCATION

College: ____
Degree Date

Medical School: ____
Degree Date

Internship: ____
Type Place Date

Residencies: ____
Type Place Date

____
Type Place Date

PROFESSIONAL HISTORY

Military Service: ____

Plastic Surgery Practice: ________________ Date Commenced in California: ________________

Board Certification: ________________ Date: ________________

Teaching Assignments: ____

Current Hospital Staffs: ____
Hospital Staff Rank

____
Hospital Staff Rank

____
Hospital Staff Rank

PROFESSIONAL SOCIETIES

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ADDITIONAL INFORMATION

1. Please email your photo to cspsoffice@att.net (minimum resolution is 300 dpi)
2. Please attach a list of your publications.

CONSENT AGREEMENT

I, ________________________, hereby consent to the California Society of plastic Surgeons, Inc., investigation into all incidents in my past that they feel, in their judgment, reflect upon my professional qualifications or my moral character. I further consent to the discussion of all information so gathered whether it be rumor or fact, true or false, with any other member of said Society. In consideration for the California Society of Plastic Surgeons, Inc., considering my membership application, I hereby covenant not to demand, through any judicial process, access to the file they accumulate in considering my application, and waive any rights I may have thereto.

Date:______________ Signature:______________________________

Return this application with supporting documents to:

California Society of Plastic Surgeons, Inc.
4269 Valley View Road, El Sobrante, CA 94803
510/243-1662 FAX 510/243-1663