

# NYS DERMATOLOGY SOCIETY MEMBERSHIP APPLICATION

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## APPLICATION FOR MEMBERSHIP

Type of Membership:      Active Member                      Associate Member                      Senior Member

Name:

Residence Address:

City:

State:

ZIP Code:

Phone:

## OFFICE ADDRESS INFORMATION

Office address:

City:

State:

ZIP Code:

Phone:

E-mail:

Fax:

Please indicate which address is your preferred mailing address:

May we send you information by e-mail:

## EDUCATIONAL INFORMATION

Medical School/Year Graduated:

Internship/Location/Dates of Service:

Residency/Location/Dates of Service:

Other Special Training (Fellowships or additional graduate training):

Medical License#/Issuing State/Date Issued:

## BOARD CERTIFICATIONS

Board of Certification

Date of Certification

## PRACTICE INFORMATION

Type of Practice

Years in Practice

Hospital Affiliations

Society Memberships

## SIGNATURES

Signature of applicant:

Date: