

# NEW YORK STATE NEUROSURGICAL SOCIETY, INC.

## Membership Application

*Print or use typewriter. Complete each space. Write "none" if question is not applicable.*

- Date of Application: \_\_\_\_\_
1. I hereby make application (circle one):  
Active Associate Special Honorary Senior Membership
2. Name: \_\_\_\_\_ 3. Date of Birth: \_\_\_\_\_  
(Last) (First) (Middle)
4. Mailing Address: \_\_\_\_\_  
(Number) (Street)  
\_\_\_\_\_  
(City) (State) (Zip) (County)  
Phone: \_\_\_\_\_ E-Mail \_\_\_\_\_
5. Location of principal professional activity: \_\_\_\_\_  
(City and State or County)
6. Sex: Male Female
7. Medical Education: \_\_\_\_\_  
(School) (City)  
\_\_\_\_\_  
(State or County) (Years) (Degree)
8. Residency: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Location and Dates)
9. Fellowship: \_\_\_\_\_  
(Location and Dates)
10. Licensed to practice medicine in: \_\_\_\_\_  
(State and Date) (License No.)  
\_\_\_\_\_  
(State and Date) (License No.)  
\_\_\_\_\_  
(State and Date) (License No.)
- ECFMG \_\_\_\_\_  
(Type and Date)
11. Membership in: \_\_\_\_\_ County Medical Society
12. Membership in American Medical Association: Yes No Date: \_\_\_\_\_

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13. Previous Membership in Neurosurgical or Component Society:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Society and Dates)

14. Certification by American Board of Neurological Surgeons: \_\_\_\_\_  
(Date)

Other: \_\_\_\_\_  
(Name and Date)

15. Present Appointments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(Indicate Institutions and Dates)

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### FOR PHYSICIANS IN FULL TIME MILITARY SERVICE ONLY

16. \_\_\_\_\_  
(Rank) (Duty Station) (Branch)

17. Date and Entry into Active Duty: \_\_\_\_\_ Expected Date of Discharge: \_\_\_\_\_

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### SPONSORS: (Two Active Members of the Society)

A. \_\_\_\_\_  
(Typed Name) (City and State) (Signature)

B. \_\_\_\_\_  
(Typed Name) (City and State) (Signature)

Applicants Signature: \_\_\_\_\_

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### FOR NEUROSURGICAL SOCIETY USE ONLY

Approved by: \_\_\_\_\_ Membership Committee  
(Signature)

Elected to: \_\_\_\_\_ membership on \_\_\_\_\_  
(Category) (Date)

Comments: \_\_\_\_\_

### RETURN COMPLETED APPLICATION WITH \$150.00 DUES TO:

Bennie Chiles, M.D., Secretary  
New York State Neurosurgical Society  
Westchester Spine and Brain Surgery, Ste. 235  
280 North Central Avenue, Hartsdale, NY 10530