



# SOUTHERN THORACIC SURGICAL ASSOCIATION

## APPLICATION FOR PRE-CANDIDATE MEMBERSHIP

(Please complete both sides)

### GENERAL

NAME: \_\_\_\_\_  
LAST FIRST MI DEGREE

DATE OF BIRTH: \_\_\_\_\_ GENDER:  M  F

CURRENT TITLE: \_\_\_\_\_

CURRENT INSTITUTION: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
CITY STATE ZIP/POSTAL CODE

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
CITY STATE ZIP/POSTAL CODE

PREFERRED MAILING ADDRESS:  OFFICE ADDRESS  HOME ADDRESS

### EDUCATION

MEDICAL SCHOOL: \_\_\_\_\_ Actual/Anticipated Graduation Date: \_\_\_\_\_

### ADDITIONAL APPLICANT INFORMATION FOR GENERAL SURGERY RESIDENTS

SITE OF GENERAL SURGERY TRAINING: \_\_\_\_\_

ANTICIPATED DATE OF COMPLETING GENERAL SURGERY RESIDENCY: \_\_\_\_\_

NAME OF PROGRAM DIRECTOR: \_\_\_\_\_

PROGRAM DIRECTOR E-MAIL ADDRESS: \_\_\_\_\_

State(s), province(s), or country(ies) in which licensed/certified to practice medicine: \_\_\_\_\_

License/Certification Number(s): \_\_\_\_\_ Date(s) Issued: \_\_\_\_\_

**THIRD-PARTY VERIFICATION OF MEDICAL STUDENTS AND GENERAL SURGERY RESIDENTS**

(Please have an STSA Member, Dean, or Program Director complete this section.)

I, \_\_\_\_\_, confirm that the applicant is a Medical Student or General Surgery resident with whom I have a professional relationship. He/she is ethically and morally fit for STSA Student Membership.

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

Medical School or Residency Program Institution: \_\_\_\_\_

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

**STATEMENT OF INTEREST IN CARDIOTHORACIC SURGERY**

(In the space provided below, please provide a brief description of your interest in cardiothoracic surgery. If this application does not provide you with enough space to complete this statement, please submit your statement separately with your application.)

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

**BASIC REQUIREMENTS FOR STSA PRE-CANDIDATE MEMBERSHIP**

An applicant for Pre-Candidate Membership must at the time of acceptance be enrolled in medical school or general surgery residency in one of the following states or regions: Alabama; Arkansas; Florida; Georgia; Kentucky; Louisiana; Maryland; Mississippi; Missouri; North Carolina; Oklahoma; South Carolina; Tennessee; Texas; Virginia; West Virginia; District of Columbia; the U.S. territories and commonwealths in the Caribbean. Applicants must submit a written statement of interest in cardiothoracic surgery.

Pre-Candidate Members may transfer to Candidate Member status once they have matched or enrolled in a thoracic surgery educational program accredited by the Residency Review Committee for Thoracic Surgery under the authority of the Accreditation Council for Graduate Medical Education that is within the STSA region.

Annual membership dues are \$25, to be billed after membership application is accepted.

**INSTRUCTIONS TO APPLICANTS**

1. Review the requirements for membership and complete this application.
2. Have your Program Director or Dean read the completed application, review the requirements, and sign the Program Director/Dean Verification portion of the application.
3. Mail or e-mail the completed application and a current version of your CV to the address below.
4. The deadline for consideration of any application is September 15. Applications received after September 15 will be deferred to the following year's committee.

Dr. Edward Savage, Membership Committee Chair  
Southern Thoracic Surgical Association  
633 N. Saint Clair St., Suite 2100  
Chicago, IL 60611-3658  
(312) 202-5892 Fax: (773) 289-0871  
E-mail: stsa@stsa.org