



SOUTHERN THORACIC SURGICAL ASSOCIATION

APPLICATION FOR ASSOCIATE MEMBERSHIP

(Please complete both pages)

GENERAL

NAME: _____
LAST FIRST MI DEGREE

DATE OF BIRTH: _____ GENDER: M F

CURRENT HOSPITAL/HEALTH SYSTEM AFFILIATION: _____

CURRENT EMPLOYER (If different from above): _____

OFFICE ADDRESS: _____

CITY STATE ZIP/POSTAL CODE

PHONE: _____ FAX: _____ E-MAIL _____

HOME ADDRESS: _____

CITY STATE ZIP/POSTAL CODE

PREFERRED MAILING ADDRESS: OFFICE ADDRESS HOME ADDRESS

EDUCATION

HIGHEST DEGREE EARNED: _____ YEAR: _____

INSTITUTION: _____

PROFESSION

(SELECT ALL THAT APPLY)

____ DATA MANAGER
____ NURSE
____ NURSE PRACTITIONER
____ PERFUSIONIST
____ PHYSICIAN ASSISTANT
____ PRACTICE ADMINISTRATOR
____ RESEARCH SCIENTIST
____ OTHER (Please specify) _____

PRACTICE

____ Salaried – Academic Medicine (medical school or university) ____ Salaried – HMO Employed (eg, Kaiser)
____ Salaried – Government (national health service, military, VA) ____ Private Practice (solo)
____ Salaried – Hospital Employed ____ Private Practice (group)
____ Other (please specify): _____

What percentage of your time is devoted to (must equal 100%):

Adult Cardiac Surgery ____% Adult Congenital Cardiac Surgery ____% Vascular Surgery ____%
General Thoracic Surgery ____% Pediatric Congenital Cardiac Surgery ____% Critical Care ____%
Other ____% (please specify): _____

THIRD-PARTY VERIFICATION

(Please have an STSA Member complete this section. Please contact STSA at stsa@stsa.org or 312.202.5892 to verify that status of an individual's membership.)

I, _____, confirm that the applicant is an allied health care professional with whom I work and who supports and works directly with cardiothoracic surgeons. He/ she is ethically and morally fit for STSA Associate Membership.

Signature: _____ Date: _____

Relationship to Applicant: _____

BASIC REQUIREMENTS FOR STSA ASSOCIATE MEMBERSHIP

Associate Membership is for scientists conducting research in the field of thoracic surgery, physician assistants, perfusionists, nurses, nurse practitioners, practice administrators, data managers and other health care professionals who support and work directly with cardiothoracic surgeons.

An applicant for Associate Membership must at the time of acceptance be working in field of allied health related to the practice of cardiothoracic surgery 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.

Active status will not become effective, nor certificate of membership presented, until the applicant attends one of the next four annual meetings following initial election to the membership. Failure to comply with this procedure will require reapplication for membership.

Annual membership dues are \$50, to be billed after membership application is accepted. New Associate Members are also subject to a one-time \$25 initiation fee.

INSTRUCTIONS TO APPLICANTS

1. Review the requirements for membership and complete this application.
2. Have one member of the Southern Thoracic Surgical Association read the completed application, review the requirements, and sign the Third-Party 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 1. Applications received after September 1 will be deferred to the following year's committee.

Dr. James J. Gangemi, 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

Contact STSA Headquarters with questions at (312) 202-5892 or stsa@stsa.org.

Learn more about STSA Associate Membership at www.stsa.org/membership.