DELAWARE SOCIETY OF ORTHOPAEDIC SURGEONS

APPLICATION FOR MEMBERSHIP

PERSONAL INFORMATION

FULL NAME: ______________________________

PRACTICE NAME: ______________________________

OFFICE ADDRESS: ______________________________

OFFICE PHONE: ______________ OFFICE FAX: ______________

E-MAIL ADDRESS: ______________________________

HOME ADDRESS: ______________________________

HOME PHONE: ______________________________

DATE OF BIRTH: ______________ SPOUSE'S NAME: ______________

PREFERRED MAILING ADDRESS: ☐ Office ☐ Home

EDUCATION

COLLEGE: ______________ YEAR OF GRADUATION/DEGREE: ______________

MEDICAL SCHOOL: ______________ YEAR OF GRADUATION/DEGREE: ______________

OTHER: ______________________________

INTERNSHIP

HOSPITAL: ______________ LOCATION: ______________ DATES: ______________

RESIDENCIES

TYPE: ______________ HOSPITAL/LOCATION: ______________ DATES: ______________
TYPE: ______________ HOSPITAL/LOCATION: ______________ DATES: ______________

FELLOWSHIPS

TYPE: ______________ HOSPITAL/LOCATION: ______________ DATES: ______________
TYPE: ______________ HOSPITAL/LOCATION: ______________ DATES: ______________

MILITARY SERVICE

BRANCH: ______________ RANK: ______________ DATES: ______________
ORTHOPAEDIC EXPERIENCE: ______________________________

CERTIFICATIONS

DATE CERTIFIED BY THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY: ______________
DATE CERTIFIED BY THE AMERICAN OSTEOPATHIC BOARD OF ORTHOPAEDIC SURGERY: ______________
DATE, FELLOW OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGERY: ______________

TEACHING AFFILIATIONS

INSTITUTION/LOCATION: ____ TITLE: ____________________

INSTITUTION/LOCATION: ____ TITLE: ____________________

HOSPITAL AFFILIATIONS

HOSPITAL/LOCATION: ____ TITLE: ____________________

HOSPITAL/LOCATION: ____ TITLE: ____________________

HOSPITAL/LOCATION: ____ TITLE: ____________________

CATEGORY OF MEMBERSHIP (Please check one only)

____ ACTIVE — Shall be limited to orthopaedic surgeons who are certified by the American Board of Orthopaedic Surgery and who practice in the State of Delaware. Shall have full voting privileges and shall be responsible for the payment of annual dues.

____ ADJUNCT — An orthopaedic surgeon not otherwise eligible for active membership. Shall pay annual dues but shall not have voting privileges.

____ ASSOCIATE — Members of allied specialties and basic sciences but not orthopaedic surgeons, whose activities, interests and contributions are related to orthopaedic surgery, shall pay annual dues but shall not have voting privileges.

OTHER PROFESSIONAL AFFILIATIONS

____ YEAR: ____________________

____ YEAR: ____________________

____ YEAR: ____________________

The following two (2) members of the Delaware Society of Orthopaedic Surgeons have been requested to forward letters of recommendation on behalf of my application.

FULL NAME: ____ PHONE: ____________________

ADDRESS: ____

FULL NAME: ____ PHONE: ____________________

ADDRESS: ____

SIGNATURE OF APPLICANT: ____

DATE: ____

Return completed application to:

Megan Hayes
900 Prides Crossing
Newark, DE 19713
PHONE: (302) 224-5181 FAX: (302) 366-1354 EMAIL: Megan.Hayes@medsocdel.org