AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

MEDICAL STUDENT ENROLLMENT FORM

Academic Year: ______________________

Clerkship Director Name: ______________________

Institution: ______________________

Address: ______________________

City/State/ZIP: ______________________

Clerkship Director Phone: ______________ E-mail: ______________

Name (Last, First)	Gender	DOB	Mailing Address If different from program address above	E-mail Address	Medical School Start Date	Anticipated Graduation Date

Note: If more space is needed, please include a second application form.

- ☐ This list serves as verification that each student is in good standing at our institution
- ☐ I am requesting an invoice to remit the $20 (per student) application fee

Clerkship Director: ______________________ Today's Date: ______________

2 EASY WAYS TO SUBMIT YOUR FORM ❶ **E-mail** enroll@facs.org ❷ **Fax** 312-202-5007 Attention Cory Suzan Petty

American College of Surgeons | 633 N. Saint Clair Street | Chicago, IL 60611-3211 | ***facs.org***