American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

RESIDENT MEMBERSHIP ENROLLMENT FORM

Institution: _____

Address: _____

City/State/ZIP: _____

Program Director Name: _____

Program Coordinator Name: _____

Program Coordinator Phone: _____ E-mail: _____

Enrollment is for (select one): ☐ Current Academic Year ☐ Next Academic Year

Name (Last, First)	Gender	DOB	Mailing Address If different from program address above	E-mail Address Personal or institutional address (cannot accept coordinator e-mail addresses)	PGY	Medical School	Medical Degree	Graduation Year	Specialty

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

☐ This list serves as verification that each resident/fellow/researcher is in good standing at our institution

☐ I am requesting an invoice to remit the $20 (per resident) application fee; PGY-1s have their application fee waived

Program Coordinator Signature: _____ Today's Date: _____

2 EASY WAYS TO SUBMIT YOUR FORM 1 **E-mail** enroll@facs.org 2 **Fax** 312-202-5007 Attention Cory Suzan Petty