



MILWAUKEE ACADEMY *of* SURGERY

for the advancement of the art and science of surgery

Application for Membership

Name	Date
Office Address	Telephone
	Fax
Place and Date of Birth	Citizenship

Pre-Medical Education	Dates (inclusive)	Degree
College		
College		

Internship	Dates (inclusive)
Hospital	
Residency	Dates (inclusive)
Hospital	
Hospital	
Hospital	
Assistantship	Dates (inclusive)
Surgeon	

Post Graduate Education	Dates (inclusive)	Degree
University		
Type of Course		

Hospital Staff Appointments	Type of Appointment	Date Started
Hospital		
Hospital		
Teaching Appointments	Position	Date Started
University		

Memberships in Medical Societies	Dates
Society	
Society	
Society	
Society	
Fellowship American College of Surgeons	Date
Certification Specialty Board	Date
Board	

Publications	Journal	Date
Title		

Signature of Applicant _____

Endorsement by Members of The Milwaukee Academy of Surgery

_____, M.D. _____, M.D.

I have read the Constitution and By Laws of The Milwaukee Academy of Surgery and I agree to support and practice the principals stated therein.

_____, M.D.

Date: _____