U.S. Resident Membership Application

(Please print or type)

*Required fields—applications will not be accepted if left blank

Name:______________________________ Date:__________
Full Legal Name

Professional Credentials:__________ *Date of Birth:__________ *Gender: ☐ Male ☐ Female
MM/DD/YY

*Home Address:______________________________

City:__________ State:__________ ZIP:__________ Country:__________

*Personal Email:__________ Institution Email:__________

*Personal Tel:__________ ☐ Home ☐ Cell Work Tel:__________

*Medical School:__________ Begin/Graduation:__________
MM/YY - MM/YY

City:__________ State:__________ Country:__________

*Residency Institution Name:______________________________

*Residency Institution Address:______________________________

*City:__________ *State:__________ *ZIP:__________ *Country:__________

*Date Started:__________ *Date of Completion:__________
MM/YY *MM/YY*

Fellowship Program Institution:______________________________

Fellowship Type:______________________________

Fellowship Institution Address:______________________________

City:__________ State:__________ ZIP:__________ Country:__________

Date Started:__________ Date of Completion:__________
MM/YY *MM/YY*

Current Program Director:______________________________

Program Director Signature: ______________________________

*Licensed to practice in: ______________________________
List All States

*Certification number:__________ ☐ ABA ☐ AOB
Date and I.D. Number

Sub-board Certification:______________________________
Type and Dates MM/YY - MM/YY

☐ I agree with the “Guidelines for the Ethical Practice of Anesthesiology” and subscribe to the “Anesthesia Care Team” statement, available at asahq.org/agreement.

Applicant’s Signature: ______________________________ **Date:** __________

For Physicians In Full-time Military Service

Residents and fellows in a military training program will be members of the Uniformed Services Society of Anesthesiologists (USSA). While in Residency, the USSA pays for ASA membership upon verification by the USSA Executive Director. Please make sure to complete the following:

Rank:____ Duty Station: ____

Branch: _____________________________________

Payment Method

Note: Dues of $25 must accompany application; the prorated amount is $12.50 after July 31.

☐ American Express ☐ MasterCard ☐ VISA ☐ Check (*Payable to American Society of Anesthesiologists*)

☐ USSA (*If checked, leave payment information blank*)

If paying by credit card, your card will be charged upon approval of your application.

Total Amount:_______________________Name on Card:____

Credit Card Number:______________________________________ Expiration Date:__________Card ID:___________________

Signature:____

The credit card number you supplied on this application may also be used to charge your component society dues, if the component accepts credit cards and charges dues. This will be a separate transaction on your statement. Those components that do not accept credit card payments and charges dues will contact you for payment of component dues. Please contact ASA Member Services at (847) 825-5586 with any questions. ***Dues are based on the calendar year.***

Membership in good standing of the American Society of Anesthesiologists
requires adherence to the ASA "Guidelines for the Ethical Practice of Anesthesiology."

Mail payment and completed form to:
American Society of Anesthesiologists
Attn: Accounting
1061 American Lane
Schaumburg, IL 60173-4973

Or fax to:
Attn: Membership (847) 825-1692