



Associate Membership Application

2100 Stewart Avenue, Suite 240
 Wausau, WI 54401
 Phone: (715) 845-9283
 Fax: (715) 848-2493
 E-Mail: ddodds@aslms.org

APPLICANT INFORMATION

First Name	Last Name	Full Middle Name
Title		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth		
Practice / Business Name		
Street Address		
Additional Address (i.e., Suite #)		City
State/Province	Zip/Postal Code	Country
Telephone		Fax
E-Mail Address		Web-Site Address

CURRICULUM VITAE / RESUME

EDUCATION *(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training).*

INSTITUTION AND LOCATION	DEGREE (If Applicable)	CALENDAR YEAR(s) ATTENDED	FIELD OF STUDY (Specialty)

BOARD CERTIFICATION

In order to be designated as being "Board Certified", an individual must have received certification from one of the following:
 (Please fill in the specialty and year certified following the applicable field).

BOARD	SPECIALTY	YEAR CERTIFIED
An American Board of Medical Specialties (ABMS) approved board.		
An organization recognized by the American Podiatric Medical Association (APMA) as qualified to certify physicians as doctors of podiatric medicine.		
An American Osteopathic Association (AOA) approved board.		
The Royal College of Physicians and Surgeons of Canada (RCPSC)		
The College of Family Physicians of Canada (CFPC)		
The American Dental Association (ADA) approved board as qualified to certify doctors of dentistry.		



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LASER EXPERIENCE (If Any)

LASER PROCEDURES

Do not list equipment manufacturers or equipment names but rather list laser and related technology procedure(s) (i.e., Hair Removal, Tattoo Removal, Skin Rejuvenation, Port Wine Stains, Lasik, Nasal Polyps, etc). ASLMS has the right to refuse any and all special laser and related technology procedures without a requirement to justify this refusal.

1.	2.	3.	4.
5.	6.	7.	8.
9.	10.	11.	12.
13.	14.	15.	16.
17.	18.	19.	20.

MEMBERSHIP CATEGORY

Associate - Any scientist, physician, other health care professional, or any individual who is qualified and duly licensed to engage in independent clinical practice and is qualified and recognized in his or her respective field. Any individual who is recognized as being significantly involved with the laser industry shall also be eligible to become a Member.

Have you ever been the subject of a criminal prosecution or of a grievance, complaint or proceeding that could have resulted in revocation, suspension, or restriction of any professional license issued to you by a governmental authority?

- Yes** If yes, please attach a statement describing the dates, nature, and outcome of the criminal prosecution or of the grievance, complaint or proceeding and any relevant information.
- No**

Has an institution or professional organization ever disciplined you, or are you currently the subject of a complaint or disciplinary proceeding within an institution or professional organization?

- Yes** If yes, please attach a statement describing the dates, nature, and outcome of the complaint or proceedings and any relevant information.
- No**

HOW DID YOU HEAR ABOUT ASLMS?

- | | |
|---|--|
| <input type="checkbox"/> ASLMS Member (Name: _____) | <input type="checkbox"/> ASLMS Annual Conference |
| <input type="checkbox"/> Referral from Industry (Company Name: _____) | <input type="checkbox"/> Direct Mailing |
| <input type="checkbox"/> Publication Ad (Publication Name: _____) | <input type="checkbox"/> ASLMS Website |
| <input type="checkbox"/> News Article (Publication Name: _____) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other Specialty Society Meetings (Name of Society: _____) | |



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DISCRIMINATION POLICY

The Society does not discriminate on the basis of race, color, religion, creed, gender, national origin, ancestry, age, disability, or sexual orientation in any aspect of its operations, including, but not limited to, the provision of services, membership on the Society's governing board or committees, and attendance at or participation in the Society's programs, grant selection, meetings, and events.

SIGNATURE

I recognize that membership in the American Society for Laser Medicine and Surgery, Inc. (ASLMS) is a privilege, not a right, and is subject to and governed by the Society's Articles of Incorporation, Bylaws, Administrative Regulations, Code of Ethics, and other rules that the Society may adopt. If accepted as a member of the Society, I agree to abide by its rules. I recognize the importance of the Society's ability to investigate the qualifications of the applicants for membership and maintain standards of conduct for its members. The Society must be able to perform its investigatory and disciplinary functions without fear of litigation by rejected applicants or disciplined members. I consent to any investigation of the facts disclosed in this application, to any disciplinary investigation during my membership in the Society, and to any statements made in the application or disciplinary process, by whomever made and whether defamatory or not. In return for consideration of my application, I consent to the Society inviting and receiving information and comment about me from any member or other person, and I agree that any information and comment furnished to the Society in response to such invitation shall be conclusively deemed confidential and privileged, and I waive any claim or cause of action and release the Society, its members, directors, officers, or agents and any person furnishing information or comment in response to an invitation from the Society for any damage or liability by reason of any action any of them take in connection with this application.

If elected to membership in the Society, I further waive any claim or cause of action against the Society, its members, directors, officers, Ethics and Conflict of Interest Committee members, agents or any person reporting, furnishing information or commenting about me in connection with any disciplinary action of the Society.

I understand that by providing my mailing address, e-mail address, telephone number, and fax number, I consent to receive communications sent by or on behalf of the ASLMS via regular mail, e-mail, telephone or fax.

Sign Full Name: _____

Date: _____

PAYMENT METHOD

Associate Member Category (Choose One)

\$240.00 (U.S.) Physician / Industry \$130 (U.S.) Scientist \$90 (U.S.) Nursing/Allied Health

\$ _____ Research Contribution (U.S.) Payment by Check (Enclosed)

\$ _____ Total (U.S.) Visa MasterCard American Express

Credit Card Number: _____ Expiration Date: _____
(Month/Year)

Signature _____

Print Name _____

SUBMIT PAYMENT

- 1) Payment by Check: Mail your application and check to ASLMS; 2100 Stewart Avenue, Suite 240; Wausau, WI 54401
- 2) Payment by Credit Card: Fax your application with credit card information (715) 848-2493 OR Email your application to ddodds@aslms.org and phone with your credit card information (715) 845-9283 or Toll Free (877) 258-6028.