



Membership Application

aslms.org

APPLICANT INFORMATION

Salutation (Mr., Ms., Mrs., Dr., Prof.) _____ Degree (i.e. MD, PhD) _____ Title _____

First Name _____ Middle Name _____ Last Name _____

Membership Status New Returning Gender Male Female Non-Binary Prefer Not to Say

TO COMPLY WITH FEDERAL REGULATIONS, ALL NON-UNITED STATES CITIZENS MUST PROVIDE THE INFORMATION INDICATED WITH A »

» Date of Birth (MM/DD/YYYY) ____/____/____ » Citizenship _____ » Passport Number _____

» Resident Address _____ » City _____ » State/Province _____

» Zip/Postal Code _____ » Country _____

Business/Practice Name _____ Business Address _____

City _____ State/Province _____ Zip/Postal Code _____ Country _____

Phone Business Home _____ Cell _____ Personal Email (Required) _____

Business Email _____ Administrative Email _____ Website URL _____

If you consent to receiving text messages from ASLMS including updates and reminders, please select the checkbox below and add your cell number above.

By selecting this checkbox, I consent to receive text messages from ASLMS (you may change this preference at any time by contacting information@aslms.org)

CURRICULUM VITAE / RESUME

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

Institution and Location	Degree (if applicable)	Graduation Date (MM/DD/YYYY)	Field of Study (specialty)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

BOARD CERTIFICATION – PHYSICIANS ONLY – *If applicable.*

To be designated as being “Board Certified,” an individual must have received certification from one of the following:

- 1) an American Board of Medical Specialties (ABMS) approved board, 2) an organization recognized by the American Podiatric Medical Association (APMA) as qualified to certify physicians as doctors of podiatric medicine, 3) an American Osteopathic Association (AOA) approved board, 4) the Royal College of Physicians and Surgeons of Canada (RCPSC), 5) the College of Family Physicians of Canada (CFPC), or 6) the American Dental Association (ADA) approved board as qualified to certify Doctors of Dentistry.

Board	Specialty	Year Certified
_____	_____	_____
_____	_____	_____

NON-PHYSICIAN SPECIALTY AND CERTIFICATION – *If applicable.*

Specialty/Certification	Year Certified
_____	_____
_____	_____

LASER EXPERIENCE

Please describe your experience _____

SOCIAL MEDIA

Personal Facebook Handle _____ Personal Instagram Handle _____

Personal LinkedIn URL _____ Personal X Handle _____

Professional Facebook Handle _____ Professional Instagram Handle _____

Professional LinkedIn URL _____ Professional X Handle _____

LASER PROCEDURES

- » List laser and related technology procedure(s) (i.e., Hair Removal, Tattoo Removal, Skin Rejuvenation, Port Wine Stains, Lasik, Nasal Polyps, etc.)
- » Do not list equipment manufacturers or equipment names.
- » 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. _____

CRIMINAL / DISCIPLINARY HISTORY – Application is not considered complete without the following information:

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 No 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.

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

ROLE WITHIN YOUR PRACTICE OR INSTITUTION / AMA MEMBER INFORMATION / AREA OF INTEREST

Primary Role _____ Secondary Role _____

Are you an AMA Member Yes No If Yes provide AMA Member Number _____

Primary Area of Interest (i.e. Aesthetics, Dermatology, Engineering, etc.) _____

WHAT DO YOU HOPE TO GAIN FROM YOUR MEMBERSHIP?

Select any that apply

Networking Education Member savings on conference & other in-person & online education Journal / Learn current research

Committee & leadership opportunities Access to the leading authors and speakers Prestige of membership in ASLMS

Other _____

HOW DID YOU HEAR ABOUT ASLMS?

ASLMS Member – Name _____ Email

Referral from Industry – Company Name _____ Direct Mailing

Publication Ad/New Article – Publication Name _____ ASLMS Website

Specialty Society Meeting – Name of Society _____ Social Media

Other _____

DISCRIMINATION POLICY / SIGNATURE REQUIRED

I recognize that membership in the American Society for Laser Medicine and Surgery, Inc. (“ASLMS” or “Society”) 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, Board Policies, membership terms and conditions, and other rules that the Society may adopt (collectively, the “Rules”). 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, email address, telephone number, and fax number, I consent to receive communications sent by or on behalf of the ASLMS via regular mail, email, telephone, or fax.

I understand and agree to the membership automatic renewal terms, including but not limited to the provisions allowing ASLMS to utilize my payment method associated with my account, and more further described here: <https://www.aslms.org/docs/default-source/member-services/automatic-renewal-terms.pdf>

Sign Full Name _____ Date _____

ANNUAL MEMBERSHIP FEES

STANDARD ANNUAL MEMBERSHIP

Associate – Any scientist, engineer, 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.

Select One \$375 (US) Physician/Industry \$180 (US) Scientist \$130 (US) Nursing/Allied Health

EARLY CAREER ANNUAL MEMBERSHIPS

2nd Year – If you have completed your training in the last two years. Must include training completion date: _____

Select One \$248 (US) Physician/Industry \$119 (US) Scientist \$86 (US) Nursing/Allied Health

1st Year – If you have completed your training in the last year. Must include training completion date: _____

Select One \$125 (US) Physician/Industry \$60 (US) Scientist \$43 (US) Nursing/Allied Health

Graduate Student – Any scientist, engineer, physician, or health care professional who has earned a bachelor's degree, and is pursuing further education in science, engineering, biology, medicine, surgery or other related discipline may be considered for Graduate Student status. Please check the category that applies.

Select One Medical Student Graduate Student Resident Intern Fellow-in-Training

Undergraduate Student – Any student who is seeking an undergraduate degree at an accredited educational institution may be admitted as an Undergraduate Student member. This class is non-voting.

Students - Application is not considered complete without the following information.

Training Currently Engaged In _____

Name of Institution _____

City _____ State/Province _____

Director/Trainer Name and Title _____ Date Training to be Completed _____

REQUIRED: A letter from your educational program specifying your completion date and degree/training pursued.

NO PAYMENT REQUIRED FOR STUDENT MEMBERSHIP - PLEASE CONTINUE TO SUBMIT APPLICATION

PAYMENT INFORMATION - IN US DOLLARS

ANNUAL MEMBERSHIP FEES (Fees are non-refundable unless application is not approved for membership)

Membership Fee Selected Above \$ _____

ASLMS Research Fund Contribution..... \$ _____

Total (USD)..... \$ _____

PAYMENT METHOD

Payment by Check Enclosed Payment must be made in US dollars only and drawn on a US bank. Make check payable to ASLMS. Individuals from countries sanctioned by the U.S. Treasury Department's Office of Foreign Assets Control must use third-country financial institutions as intermediaries for all payments to the ASLMS.

Payment by Credit Card Visa MasterCard American Express

Credit Card # _____ Expiration Date (MM/YY) _____ / _____

Name on Card (print) _____

Signature _____

SUBMIT APPLICATION

Mail your application to 100 N. 72nd Ave., Wausau, WI 54401 -OR-

» Email your application to information@aslms.org

» You may provide your credit card information via phone: (715) 845-9283 or toll Free (877) 258-6028