

# AMERICAN SOCIETY OF GENDER SURGEONS™

**Please mark which membership category you are applying for (Please refer to the membership section of [www.gendersurgeons.org](http://www.gendersurgeons.org) for information on membership categories):**

Active \_\_\_\_\_ Associate \_\_\_\_\_ Candidate \_\_\_\_\_

## PERSONAL DATA

Full Name
Designation(s)
Office Address
City/State/Country/Zip Code
Office Telephone
Office Fax
E-Mail Address
Home Address
City/State/Country/Zip Code
Cell/Home Telephone
Date of Birth/Place of Birth
Citizenship
Please indicate preferred mailing address: Home or Office

## SURGICAL SPECIALTY

Please specify your surgical specialty (mark with 'X'). Select more than one if you have dual training (or more).

General Surgery	
Plastic and Reconstructive Surgery	
Urological Surgery	
Obstetrics and Gynecology	
Otolaryngology	
Oral-Maxillofacial Surgery	
Other (Specify)	

**PROFESSIONAL QUALIFICATIONS**

<i>Pre-Medical School</i>
Name
Location
Dates/Degree
<i>Medical School</i>
Name
Location
Dates/Degree

<i>Internship or PGY 1</i>
Name
Location
Dates/Type
<i>Residency</i>
Name
Location
Dates/Type
<i>Residency (Additional)</i>
Name
Location
Dates/Type

**POST-RESIDENCY SUBSPECIALTY TRAINING (including FELLOWSHIP)**

Inclusive Dates	Program or Institution	Type of Program	Name and E-mail of Fellowship Director

**TRAINING IN GENDER SURGERY (Note: Formal training in gender surgery is not a strict criterion for membership in ASGS)**

Male-to-Female	Inclusive Dates	Program or Institution	Type of Program (Fellowship or Informal Training)	Name and E-mail of Fellowship Director
Female-to-Male	Inclusive Dates	Program or Institution	Type of Program (Fellowship or Informal Training)	Name and E-mail of Fellowship Director

**LICENSURE** Licensed to practice medicine in:

State or Country	Date	License No

**BOARD CERTIFICATION** Specialty boards completed (if applicable)

Board	Date

**MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS**

Date Admitted	Organization

**HOSPITAL AND UNIVERSITY STAFF AFFILIATIONS (subsequent to completing fellowship)**

From / To	Hospital or University and Department	Name of Chief of Service	Your Position

**PROFESSIONAL ACTIVITIES** (answer n/a if the questions does not apply)

What year did you begin practice after formal training?
How long have you been in your present position?
Number of operations performed last year?
How many of these were gender affirmation or congenital general anomaly cases?



**PUBLICATIONS:**

List each of your publications related to gender surgery, including the title, author(s), journal inclusive pages, and year. Publications in congenital gender anomalies, or other related topics may also be included. Attach additional information if necessary. Please note that publications are NOT a requirement for admission to ASGS.

1.
2.
3.
4.
5.

**PRESENTATIONS**

List each of your presentations related to gender surgery, including title of meeting, title of presentation, location, and date. Attach additional information if necessary. Presentations in congenital gender anomalies or other related topics may be included. Please note that presentations are NOT a requirement for admission to ASGS.

1.
2.
3.
4.
5.
6.

**DISCIPLINARY ACTIONS**

	YES	NO
<p>1. Has your license to practice medicine, DEA registration, or any applicable narcotic registration been:</p> <ul style="list-style-type: none"> <li>denied, limited, suspended, revoked, not renewed, or subjected to probationary conditions, or</li> <li>have you been fined or received a letter of reprimand, or</li> <li>have you voluntarily or involuntarily relinquished any such licensure or registration, or</li> <li>is any such action under investigation or pending, or</li> <li>have you been notified that the pertinent government agency is seeking such action, or</li> <li>has commenced a formal investigation toward that end?</li> </ul>		
<p>2. Have you been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for reasons relating to possible incompetence or improper professional conduct by</p> <ul style="list-style-type: none"> <li>Medicare, Medicaid, or</li> <li>any comparable public program, or is any such action now pending?</li> </ul>		
<p>3. Have you ever been convicted of, pled <i>nolo contendere</i>, or pled guilty to any felony or misdemeanor crime which may be related to your professional practice, except for minor traffic infractions?</p>		
<p>4. Have you been denied:</p> <ul style="list-style-type: none"> <li>clinical privileges, membership, certification, contractual participation, or</li> <li>employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, specialty board, professional association, medical school faculty position or other health delivery entity or system), or</li> <li>have your clinical privileges, membership, participation, certification or employment at any such organization been suspended, relinquished, reduced or otherwise restricted, revoked or not renewed, or is any such action under investigation or pending?</li> </ul>		
<p>5. Have you (either voluntarily or involuntarily) surrendered clinical privileges, terminated contractual participation or employment, or</p> <ul style="list-style-type: none"> <li>resigned from any medical organization (as defined in Questions #2 &amp; 4) while under investigation for possible incompetence or improper professional conduct, or</li> <li>in return for such an investigation not being conducted, or is any such action now pending?</li> </ul>		
<p>6. Have your privileges ever been (either voluntarily or involuntarily) denied, suspended, diminished, revoked, or not renewed or are such proceedings in progress by any peer review body, any healthcare institution, any professional medical/dental/podiatric society, any law enforcement agency, any court, or any governmental agency pertaining to your clinical or ethical performance as a physician/dentist/podiatrist?</p>		
<p>7. Have you ever (either voluntarily or involuntarily) resigned or surrendered privileges from a medical staff, a national, state or county medical/dental/podiatric society, association or organization while under investigation for possible incompetence or improper professional conduct or in return for such an investigation not being conducted or are any such proceedings in progress?</p>		
<p>8. Have you been denied certification/recertification, or</p> <ul style="list-style-type: none"> <li>have you failed examination(s) for board certification, or</li> <li>has your eligibility status changed with respect to certification/recertification by a specialty board (ABMS)?</li> </ul>		
<p>9. Have any judgments or settlements been made against you in professional liability cases, or are there now any such filed and served professional liability cases against you pending, or have you been formally notified of a professional liability claim or of an intention to commence professional liability against you? If yes, please attach additional detail.</p>		

**If you answered "Yes" to any of the questions above, please attach additional detail.**



## INSTRUCTIONS

Applicants for Active or Associate membership must be sponsored by one Active Member of ASGS, and endorsed by two other Active members. It is recommended that one of these individuals be from the candidate's local geographical area. If you do not know anyone who is a member of the Society, please leave the following fields blank, and contact the ASGS offices for sponsor recommendations.

Applicants for Candidate membership are to be proposed and sponsored by one Active or Associate member of the ASGS.

Please print your sponsor's name and information on the next page. Each sponsor and endorser will be contacted by the ASGS Central Office for a statement of support on behalf of the candidate

### Sponsor

Name
Phone Number
Email Address

### Endorser #1

Name
Phone Number
Email Address

### Endorser #2 (required for Active and Associate applicants)

Name
Phone Number
Email Address

Please include the following with a completed application:

1. A copy of your current curriculum vitae.
2. \$50 application processing fee (please fill out credit card information below).
3. Any other information which may be of relevance to the Membership Committee.

Please sign and date the complete application and send via email along with the required supporting material to the ASGS Central Office.

### **DECLARATION AND CONSENT**

As an applicant for the American Society of Gender Surgeons, I fully understand that any substantive misstatement in or omission from this application will constitute good cause for denial of admission to, or expulsion from, the Society. I attest to the accuracy of the above information.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**[CONTINUED ON NEXT PAGE]**



**CREDIT CARD AUTHORIZATION FORM (\$50 APPLICATION FEE)**

CARDHOLDER INFORMATION:

Name: \_\_\_\_\_

Billing Street Address: \_\_\_\_\_

Street Address (cont.): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Country: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

CREDIT CARD INFORMATION:

Credit Card Type: \_\_\_\_ MasterCard \_\_\_\_ Visa \_\_\_\_ American Express \_\_\_\_ Discover

Number: \_\_\_\_\_

Expiration Month: \_\_\_\_ Expiration Year: \_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Security Code: \_\_\_\_\_

\_\_\_\_ I authorize a one-time application processing fee of \$50 to my credit card.

**Send your completed application (or any questions) to:**

[membership@gendersurgeons.org](mailto:membership@gendersurgeons.org)

