



ID#: _____
Office Use

2023 – 2024 POST-GRADUATE FELLOWSHIP MEMBERSHIP APPLICATION
October 1, 2023 – September 30, 2024

Requires enrollment in 12-month Fellowship Program

Fellowship Program Information

Name of Fellowship Program: _____

Fellowship Director Name: _____

Signature of your Fellowship Director (required): _____

Fellowship Completion Date: _____



Applicant Name (PLEASE TYPE OR PRINT IN BLOCK LETTERS)

First: _____ Middle: _____ Last: _____ Suffix: _____

Previous Last Name: _____

Academic Degree Abbreviations: DPM,

Spouse Name: _____

Home Address

(Mail is sent to home address)

City: _____ ST/Province: _____ Zip/Post Code: _____ Country: _____
(OTHER THAN USA)

Phone Home: _____ Mobile: _____

Email

Primary: _____

Secondary: _____

Podiatric School AZPod (AZ) Barry (FL) CSPM (CA) DMU (IA) Kent State (OH)
 NYCPM (NY) Temple (PA) Scholl (IL) Western U (CA)

Graduation Year: _____

Residency PM&S-36 PMSR PMSR/RRA Other: _____

Residency Completion Date: _____

Residency Program Name: _____

Residency Director's Name _____

Batch # _____ Approval # _____ Amount \$ _____
Office Use

Applicant: _____

I am ABFAS Board Qualified* in

- Foot Surgery _____ (date)
- RRA Surgery _____ (date)
- Not ABFAS Board Qualified, but plan on taking exam _____ (date)
- Not ABFAS Board Qualified and do not plan on seeking status

*Applicants who are verified to be Board Qualified with ABFAS will be provided with the designation of "AACFAS". If your status is "incomplete" or no status, you will not be awarded with the "AACFAS" designation.

Website Listing

Do you agree to list your name listed in the members directory on ACFAS.org? Yes No

Date of Birth ____/____/____ (Month/Day/Year)

Gender Male Female
(For demographic purposes only)

Certificate Upon approval of my application I would like my name printed on my Post-Graduate Fellow certificate as follows:

_____, DPM, AACFAS
(Please Print Name)

Authorization I authorize the College to make such inquiries and to obtain such information as it deems necessary or appropriate to evaluate my qualifications for membership. I understand that this information will remain confidential. I further authorize any hospital, any medical staff, any medical organization and any person, who may have information that the College deems relevant to its evaluation of my application, to provide such information to the College upon its request.

By providing my name, telephone number, facsimile number(s), and e-mail address(es) and signing this form, I expressly consent to the delivery of communications promoting the commercial availability or quality of any events, goods, or services from the American College of Foot and Ankle Surgeons or its licensees or vendors, whether by facsimile, electronic mail, or regular mail. To the extent consent is given on behalf of an organization, I certify that I have authority to give such consent.

I will adhere to the By-Laws and Principles of Professional Conduct of the College.

Applicant Signature (Required) Date

Post-Graduate Fellow Dues: \$240 **October 1, 2023 – September 30, 2024** *Please allow up to 14 business days for processing.*

VISA MasterCard American Express or Check # _____ Amount Enclosed: _____ **\$240**

Credit Card Number: _____ Exp Date: ____/____ Security Code: _____

Name on Card: _____ Signature: _____ Date: _____

Completed application can be submitted by:
Upload to: <https://www.acfas.org/membershipdropbox/>
Fax to: (773) 444-1340 **Or mail to:** American College of Foot and Ankle Surgeons, Dept. 4528, Carol Stream, IL 60122-4528
Questions: Contact Madeline Giella at 773-444-1327 or maddy.giella@acfias.org.