American College of Foot and Ankle Surgeons®
Proven leaders. Lifelong learners. Changing lives.

8725 West Higgins Road
Suite 555
Chicago, Illinois 60631-2724

info@acfas.org
773-693-9300 *phone*
773-693-9304 *fax*
acfas.org
FootHealthFacts.org

Note: Online Fellow membership application available on www.acfas.org

FELLOW MEMBER APPLICATION – 2025

Board Certified status with the American Board of Foot and Ankle Surgery (ABFAS) is a requirement.

Application Type: ☐ New Fellow ☐ Fellow Reinstatement **ID#**: ________________
Office Use

NPI Number: ________________

ABFAS Board Certified in: (PLEASE TYPE OR PRINT LEGIBLY)

☐ Foot Surgery (Foot Surgery Certified meets requirement) ____________________(date)

☐ RRA Surgery ____________________(date)

Name:

First: ____________________ MI/Middle: ____________ Last: ______________________ Suffix: _____

Previous Last Name (Change due to marriage, divorce, etc.): ______________________________________

Academic Degree Abbreviations: _DPM,____

Spouse Name: ____

Principal Office/Primary Address: *This mailing address will be used in the ACFAS directory and the FootHealthFacts.org website.*

Principal Office Name: ____

Address: ____

City: ___________________________ ST/Province: __________ Zip: ___________ Country: __________
(OTHER THAN USA)

Telephone: ____________________ Fax: ______________________

Website: ____

Primary Personal Email Address*:____
**Email addresses do not appear in the ACFAS directory or FootHealthFacts.org.*

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Second Office Address: *This address will be used in the ACFAS directory and the FootHealthFacts.org website.*

Second Office Name: ____

Address: ____

City: ___________________________ ST/Province: __________ Zip: ___________ Country: __________
(OTHER THAN USA)

Telephone: ____________________ Fax: ______________________

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Batch # ____ Amount $ ______________
Office Use

Application Expires on 9/30/2025

Applicant's Name: ______________________________

Home Address:______________________________

City: ____________________ ST/Province: __________ Zip: __________ Country: __________ (OTHER THAN USA

Telephone: ______________ Fax: ______________ Mobile/Cell: ______________

Secondary Email Address:______________________________

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Podiatric School: ☐ AZCPM (AZ) ☐ Barry (FL) ☐ DMU (IA) ☐ Kent State (OH) ☐ LECOM (PA)
☐ NYCPM (NY) ☐ Scholl (IL) ☐ SMUCPM (CA) ☐ Temple (PA) ☐ UTRGV (TX)
☐ Western U (CA) **Year Graduated**: ______________

Last Residency: ☐ PM&S-24 ☐ PM&S-36 ☐ PMSR ☐ PMSR/RRA
☐ PSR-12 ☐ PSR-24 ☐ PSR-24+ ☐ PSR-36 ☐ Other: ______________

Last Residency (Hospital/Clinic) ______________________________

Last Residency Director's Name ______________________________

Year Residency Completed: ______________

Fellowship (if applicable):

Fellowship Program Name: ______________________________

Fellowship Director's Name: ______________________________

Length of Fellowship: ☐ 6 mos or less ☐ 1 year ☐ 2 years ☐ Other ______________

Year Fellowship Completed: ______________

Practice Type: (Select only one)

☐ Private Practice ☐ Multi-Specialty Group ☐ Educational Institution
☐ Partnership ☐ Orthopedic Med/Sur Group ☐ Military
☐ Podiatric Med/Sur Group ☐ Hospital ☐ VA
☐ Other ______________________________

Status in Practice: ☐ Owner ☐ Employee ☐ Partner
(Please check only one box)

State(s) in Which You Are Licensed to Practice: ______________________________

Website Listing:

Do you agree to have your name listed in the Members-Only Directory on ACFAS.org and your principal office/primary address on the ACFAS consumer practicing marketing website **FootHealthFacts.org?** ☐ Yes ☐ No

Applicant's Name: ____________________________________

Date of Birth: ____/_______/__________ (Month/Day/Year) **Gender**: ☐ Male ☐ Female ☐ Non-binary
(This section is for demographic purposes only)

Certificate:

Upon approval of my application I would like my name printed on my certificate as follows:
(Initial certificate included with membership. Additional certificates may be purchased. See payment information below.)

____, DPM, FACFAS
(Please Print Name)

All certificates are delivered to your place of business. (See next page to purchase additional certificates.)

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.

____ ______________________
Signature Required **Date**

Payment Information: ACFAS Membership Year is January 1 thru December 31. **Full Dues**: $660 **Full Tiered Dues**: $495

Applicants more than 3 years out of Residency. Pro-rated dues by month application processed**.**

Oct 2024-Jan 2025: $660	**Mar 2025:** $550	**May 2025:** $445	**Jul 2025:** $335	**Sep 2025:** $220
Feb 2025: $605	**Apr 2025:** $495	**Jun 2025:** $385	**Aug 2025:** $275	**Oct 2025–Jan 2026: Pay Full Dues**-TBD

Tiered Dues Structure. Pro-rated dues by month application processed**.**
Applicants 3 years or less out of Residency or 2 years or less out of an approved Fellowship program:

Oct 2024-Jan 2025: $495	**Mar 2025:** $410	**May 2025:** $335	**Jul 2025:** $250	**Sep 2025:** $165
Feb 2025: $455	**Apr 2025:** $370	**Jun 2025:** $290	**Aug 2025:** $205	**Oct 2025–Jan 2026: Pay Full Dues**-TBD

Application Processing fee: $95 unless ABFAS Board Certified[1] in Foot or RRA within 12 months of application processing.
[1] *Based on date identified as Board Certified by ABFAS from Exam pass date.*

Payment

Dues through 12/31/2025 (see above): $ ___________
Application Processing Fee: $ 95* *waived if ABFAS Board Certified in Foot or RRA in past 12 months
Additional Certificates ($50 each) *Optional*: $ ___________
Total Enclosed or to be Charged: $ ___________

Check No. ________________ or ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number: ________________________________ EXP DATE: ____ /____ Security Code: _________

Zip Code for Credit Card: _____________

Name of Card Holder: ____

Signature: ________________________________ Date: ______________________

Return by: **Upload to Membership Dropbox**: https://www.acfas.org/membershipdropbox/ **Fax**: 773-444-1340.
Mail: American College of Foot and Ankle Surgeons, PO Box 4528, Carol Stream, IL 60122-4528.

Questions: Contact Terry Wilkinson, PhD, CAE at 773-444-1301 or by email at terry.wilkinson@acfas.org.

Your application will be reviewed and you will receive a status response within two weeks of receipt.