



ID #: \_\_\_\_\_  
*Office Use*

## 2024-2025 First-Year Resident (PGY1) Member Application

### October 1, 2024 – September 30, 2025

Name of Residency Program: \_\_\_\_\_

Residency Director Name: \_\_\_\_\_ Email: \_\_\_\_\_

Signature of Your Residency Director Required: \_\_\_\_\_  
(Residency Director Signature)

Name: \_\_\_\_\_  
(FIRST) (MIDDLE) (LAST) (SUFFIX)

Previous Last Name: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ Unit/Apt: \_\_\_\_\_  
(Mail is sent to Resident's Local Home Address)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Fax: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Personal Email: \_\_\_\_\_

Podiatric School:  AZCPM (AZ)  SMUCPM (CA)  Barry (FL)  DMU (IA)  Scholl (IL)  
 NYCPM (NY)  Kent State (OH)  Temple (PA)  UTRGV (TX)  WesternU (CA)

Podiatric School Grad Year: \_\_\_\_\_

Residency:  PMSR  PMSR/RRA  Other \_\_\_\_\_

Residency Start Date: \_\_\_\_\_ Expected Residency Completion Date: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
(For demographic purposes only.)

**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.

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

Resident Signature

Date

**Resident Dues \$130**

**October 1, 2024 – September 30, 2025**

*Please allow up to 14 business days for processing.*

Congratulations on your recent graduation! ACFAS and its Regions are supporting your career by giving you a complimentary membership during your first year (PGY1) of Residency saving you \$130.

Remit: **Fax:** 773-693-9304 or **Mail to Lockbox:** American College of Foot and Ankle Surgeons, Department 4528, Carol Stream, IL 60122-4528. **Email:** membership@acfas.org

**Questions:** Contact Madeline Giella at 773-444-1327 or by email at maddy.giella@acfas.org.

Batch # \_\_\_\_\_ Approval # \_\_\_\_\_ Amount \$ \_\_\_\_\_

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