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

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FootHealthFacts.org

ID #: _____
Office Use

2024-2025 Resident (PGY2 & PGY3) Member Application ☐ New ☐ Reinstatement

October 1, 2024 – September 30, 2025

**Submit your application ASAP to start receiving your benefits immediately!*

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 Name**: _____

Home Address: _____ **Unit/Apt**: _____
(Journal is sent to home address.)

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Mobile**: _____ **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.***

☐ VISA ☐ MasterCard ☐ American Express or Check # _____ Amount Enclosed: **$130**

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

Name on Card: _____ Signature: _____ Date: _____

Upload to: https://www.acfas.org/membershipdropbox/

Fax to: (773) 444-1340 **Or mail to:** American College of Foot and Ankle Surgeons, PO Box 4528, Carol Stream, IL 60122-4528 **Questions?** Contact Madeline Giella at (773) 444-1327 or by email to maddy.giella@acfas.org.

Office Use
Batch # _____ Approval # _____ Amount $ _____