ASDS American Society for Dermatologic Surgery

COSMETIC AND RECONSTRUCTIVE EXPERTISE
FOR YOUR *skin health and beauty*℠

ASDSA American Society for Dermatologic Surgery ASSOCIATION

Adjunct Member Application

ELIGIBILITY

Any individual who works for a commercial firm, consultant or other organization that supplies products and/or services to the dermatology/dermatologic surgery market and who is not directly involved in patient care shall be eligible to be an Adjunct Member. Adjunct Members shall have the right to attend membership meetings and to serve on committees and councils but shall not be eligible to vote or serve in elective office.

APPLICATION PROCESS

The ASDS office will notify applicants when their application is complete. An application is complete only when the form and application fee have been received. Upon acceptance into membership, applicants will receive *Currents* and *Dermatologic Surgery* journal, access to the ASDS website and be able to register for meetings and purchase most ASDS products at member rates.

Annual membership dues: $625

APPLICANT INFORMATION

Name _____
FIRST / GIVEN MIDDLE LAST / FAMILY

Gender ☐ Male ☐ Female **Birth year** _____

Please specify ☐ Home ☐ Office

Company / Organization name _____

Address _____

_____

City _____ **State** _____ **Postal code** _____

Country _____

Telephone _____ **Fax** _____
(Outside U.S., include country/city codes) *(Outside U.S., include country/city codes)*

Cell phone _____
(Outside U.S., include country/city codes)

E-mail _____ **Website** _____

REVIEW AND SIGNATURE

I hereby request and authorize the evaluation and validation of my credentials in accordance with, and subject to, the rules and procedures of the American Society for Dermatologic Surgery. I hereby waive any claim for damages, or otherwise, that I may have against any organization or individual who supplies information with respect to my application, ASDS, its officers, directors, members, employees and agents by reason of any act of omission or commission that they, or any of them, may take in good faith in connection with this application. I understand the decision as to whether or not I qualify for membership vests solely and exclusively in ASDS and that its decision is final.

I understand I have an obligation to pay annual membership dues if I am accepted for ASDS membership. I represent the information provided in this application is truthful and accurate.

Signature _____ **Date** _____

INDICATE METHOD OF PAYMENT BELOW

A non-refundable application fee of $95 is required and must accompany the application.

☐ MasterCard ☐ Visa ☐ American Express ☐ Discover ☐ Check payable to ASDSA (US Dollars only)

Account Number _____ **Billing ZIP code** _____ **Expiraton Date** _____

Cardholder Name (print) _____ **Authorized Signature** _____

Return completed membership application and a non-refundable $95 application fee to:

American Society for Dermatologic Surgery Association
5550 Meadowbrook Drive, Suite 120
Rolling Meadows, IL 60008-3805
Phone: 847-956-0900 • Fax: 847-956-0999

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