ASSOCIATE ACTIVE MEMBERSHIP REQUIREMENTS:
- Practice within the United States, Canada or Puerto Rico.
- License to practice medicine in his/her state, province or country. Applicant may be in government service not requiring licensure.
- Certification by an American Surgical Specialty Board (other than the American Board of Surgery, the American Board of Osteopathic Surgery, fellowship in the Royal College of Surgeons, Canada, or fellowship in the American College of Surgeons) that is a member of the American Board of Medical Specialties and appropriate to applicant’s specialty practice, or certification in gastroenterology by the American Board of Internal Medicine, or appropriate equivalent specialty certification by the Royal College of Physicians and Surgeons of Canada.
**EDUCATION:**

<table>
<thead>
<tr>
<th>College/University: Institution</th>
<th>Degree</th>
<th>Date Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical School: Institution</td>
<td>Degree</td>
<td>Date Awarded</td>
</tr>
<tr>
<td>Postgraduate Training: Institution</td>
<td>Degree</td>
<td>Date Awarded</td>
</tr>
<tr>
<td>Internship: Institution</td>
<td>Program Director</td>
<td>Inclusive Dates</td>
</tr>
<tr>
<td>Residency: Institution</td>
<td>Program Director</td>
<td>Inclusive Dates</td>
</tr>
<tr>
<td>Fellowship: Institution</td>
<td>Program Director</td>
<td>Inclusive Dates</td>
</tr>
<tr>
<td>Other: Institution</td>
<td>Program Director</td>
<td>Inclusive Dates</td>
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</tbody>
</table>

**MEDICAL LICENSURE:**

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<tr>
<th>State</th>
<th>Registry Number</th>
<th>Expiration Date</th>
</tr>
</thead>
</table>

Has your medical license ever been suspended or revoked in any state? □ Yes □ No
Have your privileges ever been suspended or changed? □ Yes □ No

**BOARD CERTIFICATION:**

- Certified by an American Surgical Specialty Board
- Certified by the American Board of Internal Medicine
- Certified by the Royal College of Physicians and Surgeons of Canada

**FELLOWSHIPS and MEMBERSHIPS:**

- AMA □ ASGE □ AUA □ ASCRS □ AAGL □ AWS □ SBAS □ Other ____________________________

**CURRENT ENDOSCOPIC/LAPAROSCOPIC EXPERIENCE** (NOT NECESSARY TO HAVE EXPERIENCE IN ALL THESE PROCEDURES):

**FLEXIBLE GI ENDOSCOPY**

(Approximate # Past 12 months/3 years/Complications)

- EGD #___/#___/#____ □ TEACH?
- ERCP #___/#___/#___ □ TEACH?
- PEG #___/#___/#___ □ TEACH?
- COLONOSCOPY #___/#___/#___ □ TEACH?
- OTHER ____________________________

□ Please feel free to expand on training or surgical experience in this box

**LAPAROSCOPIC GENERAL SURGERY**

(Approximate # Past 12 months/3 years/Complications)

- LAPAROSCOPY #___/#___/#___ □ TEACH?
- LAPAROSCOPIC CHOLECYSTECTOMY #___/#___/#___ □ TEACH?
- LAPAROSCOPIC CHOLEDOCHOSCOPY #___/#___/#___ □ TEACH?
- UPPER GI LAPAROSCOPIC SURGERY #___/#___/#___ □ TEACH?
- LOWER GI LAPAROSCOPIC SURGERY #___/#___/#___ □ TEACH?
- LAPAROSCOPIC SOLID ORGAN REMOVAL #___/#___/#___ □ TEACH?

**ENDOSCOPIC and LAPAROSCOPIC TRAINING:**

Was **FLEXIBLE ENDOSCOPY** included in your surgical residency or fellowship training? □ Yes □ No
If yes, who was your Endoscopic Instructor? ____________________________

Was **LAPAROSCOPIC SURGERY** included in your surgical residency or fellowship training? □ Yes □ No
If yes, who was your Instructor? Date: __________________ Instructor: ____________________________

Did you receive training from a course or program? Date: __________________ Course/Program: ____________________________

Location: ____________________________ Course/Program Instructor: ____________________________
ACADEMIC APPOINTMENTS (BEGIN WITH CURRENT):

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<tr>
<th>Institution</th>
<th>Title</th>
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CLINICAL? □ FULL TIME? □

HOSPITAL APPOINTMENTS (BEGIN WITH CURRENT):

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PRACTICE PATTERNS (INDICATE YOUR SURGICAL PRACTICE AS IT IS NOW DEFINED):

- Private Practice Solo
- Private Practice Group
- Private Practice/Part Time HMO
- Military
- Full Time HMO or IPA
- Full Time Academic
- Full Time Government (VA)
- Other

AUTHORIZATION: I authorize the Society of American Gastrointestinal and Endoscopic Surgeons to obtain information from societies, hospital staffs, members and any other source regarding this application and my qualifications for membership that will be kept confidential by the Society.

Applicant's Signature: ________________________________

SPONSORS:

Current SAGES Member: ____________________________ Email: ____________________

Program Director: ____________________________ Email: ____________________

CHECKLIST FOR REQUIRED DOCUMENTS TO COMPLETE APPLICATION:

- A signed, fully completed application form (or complete an online application at www.sages.org)
- A copy of your current medical license
- A copy of your certificate from an American Surgical Specialty Board, the American Board of Internal Medicine, the American College of Surgeons or the Royal College of Surgeons
- Documented experience in minimal access surgery (e.g., endoscopy, laparoscopy, thoracoscopy, robotics) in a surgical field other than gastrointestinal surgery, or documented recognition and expertise in advanced therapeutic gastroenterologic endoscopy, by applicant dedicated to goals and objectives of the Society
- TWO letters of recommendation from two individuals describing applicant’s competency in the field of minimal access surgery:
  - A letter from a current SAGES member. (or request an introduction by emailing membership@sages.org)
  - A letter from the Chief/Chair of Surgery/ Chief of Staff, or applicant’s Program Director/instructor in endoscopy or laparoscopy, or a physician familiar with your practice
- Application fee of $100

PLEASE FIND ENCLOSED MY $100 USD APPLICATION FEE:

- A check (USD only) is enclosed with this application. Please make checks payable to SAGES.
  - CC Number: ___________________________ Expiration Date: _____________ Code:________ Amount: _____________
  - I authorize you to charge my: □ VISA □ MasterCard
  - Cardholder Name: ________________________________ Signature: ______________________

or remit payment online at: https://www.sages.org/sages-membership-application-fee/

APPLICATION REVIEW PROCESS: The SAGES Membership Committee meets quarterly, in January, March/April, July, and October, to consider new members. Applications must be complete one month prior to final approval meeting dates.

ANNUAL MEMBERSHIP DUES: Annual dues for Active members are $350 and includes your online subscription to the Surgical Endoscopy journal. Dues are invoiced AFTER acceptance into membership.