SAGES

Society of American Gastrointestinal and Endoscopic Surgeons

APPLICATION FOR ACTIVE MEMBERSHIP

SAGES Membership Services
11300 W Olympic Blvd #600
Los Angeles CA 90064
Phone: 310-437-0544
Fax: 310-437-0585
Email : membership@sages.org
Web Site : www.sages.org

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 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.

PLEASE TYPE OR PRINT CLEARLY Application Date: _____ Please Check: ☐ Male ☐ Female ☐ Active Military

APPLICANT'S FULL NAME:

_____

(**LAST**/FAMILY NAME) (**FIRST**/GIVEN NAME) (**MIDDLE** NAME OR INITIAL)

☐ MD ☐ DO ☐ PhD ☐ FACS ☐ FRCS ☐ Other Degrees: _____

Date of Birth (month/day/year): _____ Country of Birth _____

SURGICAL SPECIALITY: _____

PLEASE CHECK PREFERRED MAILING ADDRESS:

☐ **PROFESSIONAL ADDRESS**:

_____
(Company or Organization or Institution)

_____
(Department) (Title)

_____
(Street Address) (Suite or Room or Building or PO Box)

_____
(City) (State/Province) (Zip/Postal Code) (Country)

_____
(Business Phone Number) (Business Fax Number) (Business E-Mail Address)

☐ **RESIDENCE ADDRESS**:

_____
(Street Address) (Apt Number or Box Number)

_____
(City) (State/Province) (Zip/Postal Code) (Country)

_____
(Home or Cell Phone Number) (Personal E-Mail Address)

EDUCATION:

College/University: Institution	Degree	Date Awarded
Medical School: Institution	Degree	Date Awarded
Postgraduate Training: Institution	Degree	Date Awarded
Internship: Institution	Program Director	Inclusive Dates
Residency: Institution	Program Director	Inclusive Dates
Fellowship: Institution	Program Director	Inclusive Dates
Other: Institution	Program Director	Inclusive Dates

MEDICAL LICENSURE:

State	Registry Number	Expiration Date

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 the American Board of Surgery Certificate #: _____ Exp Date: _____
☐ Certified by the American Board of Osteopathic Surgery Certificate #: _____ Exp Date: _____
☐ Fellow of the American College of Surgery Certificate #: _____ Exp Date: _____
☐ Fellow of the Royal College of Surgeons Certificate #: _____ Exp Date: _____

FELLOWSHIPS and MEMBERSHIPS:

☐AMA ☐ASCRS ☐ASGE ☐SSAT ☐AOA ☐ASMBS ☐IPEG ☐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 # ____ / # ____/ #____
☐ ERCP # ____ / # ____/ #____
☐ PEG # ____ / # ____/ #____
☐ COLONOSCOPY # ____ / # ____/ #____

☐ OTHER_____

LAPAROSCOPIC GENERAL SURGERY

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

☐ LAPAROSCOPY # ____ / # ____/ #____
☐ LAPAROSCOPIC CHOLECYSTECTOMY # ____ / # ____/ #____
☐ LAPAROSCOPIC CHOLEDOCHOSCOPY # ____ / # ____/ #____
☐ UPPER GI LAPAROSCOPIC SURGERY # ____ / # ____/ #____
☐ LOWER GI LAPARSCOPIC SURGERY # ____ / # ____/ #____
☐ LAPAROSCOPIC SOLID ORGAN REMOVAL # ____ / # ____/ #____

ENDOSCOPIC and LAPAROSCOPIC TRAINING:

Is/Was **FLEXIBLE ENDOSCOPY** included in your surgical residency or fellowship training? ☐ Yes ☐ No
If yes, who is/was your Endoscopic Instructor? _____ Inclusive Dates: _____
Endoscopic Instructor? _____ Inclusive Dates: _____
Endoscopic Instructor? _____ Inclusive Dates: _____

Is/Was **LAPAROSCOPIC SURGERY** included in your surgical residency or fellowship training? ☐ Yes ☐ No
If yes, who is/was your Instructor? _____ Inclusive Dates: _____
Instructor? _____ Inclusive Dates: _____
Instructor? _____ Inclusive Dates: _____

ACADEMIC APPOINTMENTS (BEGIN WITH CURRENT):

_____ ☐ CLINICAL? ☐ FULL TIME?
Institution Title Inclusive Dates

_____ ☐ CLINICAL? ☐ FULL TIME?
Institution Title Inclusive Dates

_____ ☐ CLINICAL? ☐ FULL TIME?
Institution Title Inclusive Dates

HOSPITAL APPOINTMENTS (BEGIN WITH CURRENT):

_____
Institution Inclusive Dates

_____
Institution Inclusive Dates

_____
Institution Inclusive Dates

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

I consider myself primarily to be:

☐ Academic Surgeon ☐ Community Practice Surgeon

SPONSORS:

Current SAGES Member: _____ Email:_____

Surgeon Colleague: _____ Email: _____

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: _____

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 the American Board of Surgery, the American Board of Osteopathic Surgery, the American College of Surgeons or the Royal College of Surgeons

TWO letters of recommendation from two individuals describing applicant's training, skill and experience in the practice of endoscopy and/or laparoscopy:

☐ A letter from a current SAGES member. (or request an introduction by emailing membership@sages.org)
☐ A letter from your current Chief of Surgery or a previous endoscopic instructor or a surgical colleague who is familiar with your endoscopic practice
☐ Application fee of $100 (or provide Promo Code)

PROMO CODE: _____

PLEASE FIND ENCLOSED MY $100 USD APPLICATION FEE:

☐ A check (USD only) is enclosed with this application. Please make checks payable to SAGES.

☐ I authorize you to charge my: ☐ VISA ☐ MasterCard ☐ AMERICAN EXPRESS ☐ DISCOVER

CC Number: _____ Expiration Date: _____ Code:_____Amount: _____

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.