



# 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](mailto:membership@sages.org)  
Web Site : [www.sages.org](http://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.

Application Date: \_\_\_\_\_ Please circle: Male of Female PLEASE TYPE OR PRINT CLEARLY

### 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 \_\_\_\_\_

### 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:**

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

**MEDICAL LICENSURE:**

State	Registry Number	Expiration Date
Has your medical license ever been suspended or revoked in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have your privileges ever been suspended or changed? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**BOARD CERTIFICATION:**

<input type="checkbox"/> Certified by the American Board of Surgery	Certificate #: _____	Exp Date: _____
<input type="checkbox"/> Certified by the American Board of Osteopathic Surgery	Certificate #: _____	Exp Date: _____
<input type="checkbox"/> Fellow of the American College of Surgery	Certificate #: _____	Exp Date: _____
<input type="checkbox"/> Fellow of the Royal College of Surgeons	Certificate #: _____	Exp Date: _____

**FELLOWSHIPS and MEMBERSHIPS:**

AMA  ASCRS  ASGE  SSAT  EAES  AOA  ASMBS  IPEG  MIRA  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 \_\_\_\_\_

**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):**

_____	_____	_____	<input type="checkbox"/> CLINICAL? <input type="checkbox"/> FULL TIME?
Institution	Title	Inclusive Dates	
_____	_____	_____	<input type="checkbox"/> CLINICAL? <input type="checkbox"/> FULL TIME?
Institution	Title	Inclusive Dates	
_____	_____	_____	<input type="checkbox"/> CLINICAL? <input type="checkbox"/> 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):**

<input type="checkbox"/> Private Practice Solo	<input type="checkbox"/> Private Practice Group	<input type="checkbox"/> Private Practice/Part Time HMO	<input type="checkbox"/> Military
<input type="checkbox"/> Full Time HMO or IPA	<input type="checkbox"/> Full Time Academic	<input type="checkbox"/> Full Time Government (VA)	<input type="checkbox"/> 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:** \_\_\_\_\_

**CHECKLIST FOR REQUIRED DOCUMENTS TO COMPLETE APPLICATION:**

- A signed, fully completed application form
- 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
- A letter from your current Chief of Surgery or a previous endoscopic instructor or a surgical colleague who is familiar with your endoscopic practice
- Payment for the \$100 application fee

**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

CC Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Amount: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**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 subscription to the *Surgical Endoscopy* journal. Dues are invoiced AFTER acceptance into membership.