*The **N**ew **Y**ork **S**ociety for*
***S**urgery of the **H**and*

Membership Application

Name: ____ **Date:** ____/____/____

Date Of Birth: ___/___/19____ **Location:** ______________________________ **Citizenship:**____________________

Residential Address	**Office Address**
______________________	______________________
______________________	______________________
______________________	______________________
Phone	Phone
Fax/E-Mail	Fax/E-Mail

EDUCATION

Pre-Medical	**Medical Education**
College or University	Medical School
Address	Address
City, State & Zip Code	City, State &Zip Code
Dates Attended	Dates Attended
Degree	Degree

Post-Graduate Training	**Post-Graduate Training**
Facility	Facility
Address	Address
City, State & Zip Code	City, State & Zip Code
Dates Attended	Dates Attended
Department	Department

EDUCATION CONTINUED...

Post-Graduate Training	**Hand Surgery Fellowship**
______________________ Facility	______________________ Facility
______________________ Address	______________________ Address
______________________ City, State & Zip Code	______________________ City, State & Zip Code
______________________ Dates Attended	______________________ Dates Attended
______________________ Department	______________________ Department & Director

LICENSURE

State:__________ License Number:________________________ Date Issued:________________Valid Through:______________

State:__________ License Number:________________________ Date Issued:________________Valid Through:______________

State:__________ License Number:________________________ Date Issued:________________Valid Through:______________

BOARD CERTIFICATION

Are you a current Diplomat of the American Board of Orthopedic Surgery, Plastic Surgery or General Surgery Yes No

If yes, what is your original certification date? _________________ When is it valid through? __________________

Are you currently certified in the sub-specialty of hand surgery? Yes No Pending

If no, have you or are you scheduled for the exam? ____

TEACHING APPOINTMENTS

Institution:___________________________________ Title:____________________________________ Date:__________________

Institution:___________________________________ Title:____________________________________ Date:__________________

Institution:___________________________________ Title:____________________________________ Date:__________________

HOSPITAL APPOINTMENTS

Facility:___________________________________ Title:____________________________________ Date:___________________

*The **N**ew **Y**ork **S**ociety for*
***S**urgery of the **H**and*

Facility:____________________ Title:____________________ Date:__________

Facility:____________________ Title:____________________ Date:__________

PROFESSIONAL AFFILIATIONS

Society:____________________ Position:____________________ Date:__________

Society:____________________ Position:____________________ Date:__________

Society:____________________ Position:____________________ Date:__________

Society:____________________ Position:____________________ Date:__________

REFERENCES

***** MUST be active members of NYSSH who are aware of your PRESENT professional activities*****

Name:____________________ Address:____________________Telephone:__________

Name:____________________ Address:____________________Telephone:__________

Name:____________________ Address:____________________Telephone:__________

Have you ever been convicted of a felony? **Yes** **No**

Have you ever had any license to practice medicine restricted and/or revoked, either through governmental action or voluntary surrender? **Yes** **No**

Have you ever had a hospital membership and/or privileges restricted, revoked and/or denied? **Yes** **No**

Have you ever had any membership in any society and/or association revoked, restricted and/or denied? Yes No

Have you ever been censured by a state, medical society and/or a hospital? **Yes** **No**

****If you answered yes to any of these questions, please provided additional information explaining the reason, outcome and/or status of the situation****

ADDITIONAL INSTRUCTIONS

Include a typed list of all surgical procedures you performed in the **year preceding** your application. List separately hand and non-hand procedures. Data compiled for the **most recent** CAQHS examination may be used to satisfy this requirement.

Estimate the percentage of hand patients seen in your practice for the year preceding this application. __________%

Attach a list of publications and presentations.

It is the **responsibility of the applicant** to have the application, including all letters of references, completed and submitted prior to **January 30**. Applications received after this date **will not be** considered and reapplication will be required.

AUTHORIZATION

In furtherance of my application for membership, I request and authorize the NYSSH to evaluate and validate my credentials and information submitted for this application. I request and authorize any entity who may have information which they deem relevant to my fitness for membership, to provide such information to the NYSSH.

I hereby waive any claim for damages, or otherwise, that I may have against any hospital, medical staff, medical organization, or individual who supplies information with the respect to my application, the NYSSH, its officers, members, employees and agents 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 that the decision as to whether I qualify for membership vests solely and exclusively in the NYSSH and that its decision is final.

I certify that my answers submitted for this application are complete, true and correct to the best of my knowledge.

____ Date:______________________
Signature

____
Print Name

All data should be submitted to the Secretary of the NYSSH:

Jack Choueka, MD
927 49th St.
Brooklyn, NY 11219