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

Membership Application

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

Date of Birth:___/___/___ **Location:**____________________ **Citizenship:**_______________

Residential Address	**Office Address**
Email Address:	Office Phone:
Mobile #:	Office Fax:

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
Addres	Addres
s	s
City, State & Zip Code	City, State & Zip Code
Dates Attended	Dates Attended
Department	

EDUCATION CONTINUED...

Post-Graduate Training	**Hand Surgery Fellowship**
Facility	Facility
Addres s	Addres s
City, State & Zip Code	City, State & Zip Code
Dates Attended	Dates Attended

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

Ifno, 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:______________

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 31st**. 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

The complete application, supporting documents and letter of references should be emailed to:

The NYSSH Secretary at NYSSH1@gmail.com.

If you have any questions regarding your application,
please email the NYSSH Secretary at NYSSH1@gmail.com