



CSPS MEMBERSHIP APPLICATION

Name: _____

Business Address: _____
Street City State Zip

Business Phone: _____ FAX: _____ Email: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Spouse Name (if applicable): _____ Voting District: _____

EDUCATION

College: _____
Degree Date

Medical School: _____
Degree Date

Internship: _____
Type Place Date

Residencies: _____
Type Place Date

Type Place Date

PROFESSIONAL HISTORY

Military Service: _____

Plastic Surgery Practice: _____ Date Commenced in California: _____

Board Certification : _____ Date: _____

Teaching Assignments: _____

Current Hospital Staffs: _____
Hospital Staff Rank

Hospital Staff Rank

Hospital Staff Rank

PROFESSIONAL SOCIETIES

ADDITIONAL INFORMATION

1. Please email your photo to cspsoffice@earthlink.net (minimum resolution is 300 dpi)
2. Please attach a list of your publications.

CONSENT AGREEMENT

I, _____, hereby consent to the California Society of plastic Surgeons, Inc., investigation into all incidents in my past that they feel, in their judgment, reflect upon my professional qualifications or my moral character. I further consent to the discussion of all information so gathered whether it be rumor or fact, true or false, with any other member of said Society. In consideration for the California Society of Plastic Surgeons, Inc., considering my membership application, I hereby covenant not to demand, through any judicial process, access to the file they accumulate in considering my application, and waive any rights I may have thereto.

Date: _____ Signature: _____

Return this application with supporting documents to:

California Society of Plastic Surgeons, Inc.
3664 San Pablo Dam Road, El Sobrante, CA 94803
510/243-1662; FAX 510/243-1663