APPLICATION FOR ASSOCIATE MEMBERSHIP

SOUTH CAROLINA ACADEMY OF DERMATOLOGY AND DERMATOLOGIC SURGERY
PO BOX 11188, COLUMBIA, SC 29211

PLEASE PRINT OR TYPE

NAME:____ DATE OF BIRTH_______________

OFFICE ADDRESS:____

OFFICE PHONE:__________________________ FAX:_______________________________

HOME ADDRESS:____

HOME PHONE:________________________ SPOUSE'S NAME:__________________ ____

EMAIL ADDRESS:____

COLLEGE:_____________________________________ DATES:_______________________

____ DATES:_______________________

____ DATES:_______________________

DERMATOLOGY EXPERIENCE:____

DATES:_______________________

AMERICAN ACADEMY OF DERMATOLOGY: (Please Check)

FELLOW_______ ASSOCIATE __X____ BOARD ELIGIBLE_______ DATE:_________

OTHER PROFESSIONAL ASSOCIATIONS:______________________________________

____

CIVIC CLUBS AND OFFICES: (optional)____

PHYSICIAN MEMBERS SPONSORING APPLICANT: (Two Required)

1.___________________________________2.______________________________________

SIGNED:_______________________________ DATE:_______________________________