



AMERICAN COLLEGE OF GASTROENTEROLOGY

6400 Goldsboro Road, Suite 450, Bethesda, Maryland 20817-5846

Telephone: 301-263-9000, Fax: 301-263-9025

MEMBERSHIP APPLICATION

I hereby apply for the following category of membership (Initial application is made for Member or International Member. Following three years of affiliation, members who meet the criteria set forth in Article 1, Section 2(b) of the ACG Bylaws may apply for Advancement to Fellowship. For more information on Membership qualifications, visit us online at www.acg.gi.org to view the ACG Bylaws.):

Member

International Member (Verification of GI training must be attached)

CONTACT INFORMATION (Copy of CV must be attached)

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Practice/Hospital/Univ: _____ Address: _____

City: _____ State: _____ Zip/Postal Code: _____ Country: _____

E-mail: _____

Phone (Int'l include country and city codes for all numbers): _____ Fax: _____

Home Address: _____ City: _____ State: _____

Zip/Postal Code: _____ Country: _____ Home Phone: _____

Please mail materials to my: Office Address Home Address

OPTIONAL: Spouse's Name (will be contacted by the Auxiliary): _____

EDUCATION

University: _____ Degree: _____ Date Awarded: _____

Medical School: _____ Degree: _____ Date Awarded: _____

POSTGRADUATE TRAINING

Internship: _____ Institution: _____ Inclusive Dates: _____

Residency: _____ Institution: _____ Inclusive Dates: _____

Fellowship: _____ Institution: _____ Inclusive Dates: _____

Other: _____ Institution: _____ Inclusive Dates: _____

MEDICAL LICENSURE/BOARD CERTIFICATIONS (copies of the board certificates must be attached)

Name on medical license: _____ State / Country: _____ Registry #: _____

Specialty Board: _____ Certificate #: _____ Date: _____

Sub-Specialty Board: _____ Certificate #: _____ Date: _____

HOSPITAL APPOINTMENTS (begin with current)

Hospital: _____ Position: _____ Inclusive Dates: _____

Hospital: _____ Position: _____ Inclusive Dates: _____

Hospital: _____ Position: _____ Inclusive Dates: _____

ACADEMIC APPOINTMENTS (begin with current)

Institution: _____ Position: _____ Inclusive Dates: _____
Institution: _____ Position: _____ Inclusive Dates: _____
Institution: _____ Position: _____ Inclusive Dates: _____
Institution: _____ Position: _____ Inclusive Dates: _____

I am am not at present engaged in private practice in addition to my present teaching duties.

I currently teach: Full-time Part-time Hours per week: _____

RESEARCH & PUBLICATIONS

If available, please attach separately.

DEMOGRAPHICS (Optional)

Gender: Male Female

Research: Do you participate in Clinical Research? Yes No
Do you participate in Basic Research? Yes No

Practice Setting: Private Practice: Academic: Non-Practice Setting / Other
(check all that apply) Solo Practice _____ % Pure Clinician
 Practice with 5 or fewer MDs _____ % Clinical Educator
 Practice with 6 or more MDs _____ % Basic Science Researcher
 Multi-specialty group

Areas of Interest / Specialty: Biliary Colon Endoscopy Esophagus Functional Bowel Disease
 Geriatrics IBD Liver/Hepatology Motility Oncology
 Outcomes Studies Pancreas/Small Bowel Pediatrics Stomach

PROPOSER INFORMATION

Your Proposer, who can either be a Member or a Fellow of the College, will need to send a letter supporting your application. You may attach the letter to your application or it can be mailed separately to the ACG.

Proposer's Name: _____

Proposer's Phone Number: _____ E-mail Address: _____

Signature of Applicant: _____

PAYMENT INFORMATION

Application Fee: \$195 (Payment must be submitted with application in U.S. Dollars only.)

My check made payable to the ACG is enclosed. My credit card information is below.

Visa MasterCard American Express

Credit Card Number: _____ Exp. Date: _____ 3 or 4 Digit Security Code: _____

Name on card: _____ Signature: _____

This section for use by ACG Governors only.

Action by Governor: Approved Not-Approved Signature of Governor: _____

Explanation: _____

