



# AMERICAN COLLEGE OF GASTROENTEROLOGY

6400 Goldsboro Road, Suite 200, Bethesda, Maryland 20817-5842

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

## RESIDENT / TRAINEE MEMBERSHIP APPLICATION

### QUALIFICATIONS FOR RESIDENT / TRAINEE MEMBERSHIP

- The applicant for Resident / Trainee Membership shall be a graduate of a medical school which is recognized by the Council on Medical Education of the American Medical Association and shall possess the degree of Doctor of Medicine or Doctor of Osteopathy.
- Residents shall be enrolled in approved training programs, which include some exposure to gastroenterology, GI endoscopy, hepatology or gastrointestinal surgery.
- Fellows shall be enrolled in an approved gastroenterology fellowship program.
- The applicant shall make application for Resident / Trainee Membership on the prescribed form and shall be approved by the Credentials Committee.
- For more information on Membership qualifications, visit us online at [gi.org](http://gi.org).

### CONTACT INFORMATION

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_ NPI Number (*required for U.S. physicians only*): \_\_\_\_\_

Office 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: \_\_\_\_\_ Phone: \_\_\_\_\_

Please mail materials to my:  Work Address  Home Address

OPTIONAL: Spouse's Name (*will be contacted by the Auxiliary*): \_\_\_\_\_

### EDUCATION

University: \_\_\_\_\_ Degree: \_\_\_\_\_ Date Awarded: \_\_\_\_\_

Medical School: \_\_\_\_\_ Degree: \_\_\_\_\_ Date Awarded: \_\_\_\_\_

Internship Institution: \_\_\_\_\_ Inclusive Dates: \_\_\_\_\_

Residency Institution: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

### CURRENT TRAINING PROGRAM (*if applicable*)

Institution: \_\_\_\_\_ Program Director: \_\_\_\_\_

Start Date of GI Fellowship: \_\_\_\_\_ End Date of GI Fellowship: \_\_\_\_\_

**SPECIAL TRAINING AND EXPERIENCE**

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**BOARD CERTIFICATION**

Specialty Board: \_\_\_\_\_ Certificate #: \_\_\_\_\_ Date: \_\_\_\_\_

**MEMBERSHIP IN MEDICAL SOCIETIES**

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**DEMOGRAPHICS** (Optional)

Gender:  Male  Female

Areas of Interest / Specialty:  Biliary  Colon  Endoscopy  Esophagus  Functional  General GI  
(check all that apply)  Geriatrics  IBD  Liver / Hepatology  Motility  Oncology  Outcomes Studies  
 Pancreas  Pediatrics  Small Bowel  Stomach

Name of Program Director: \_\_\_\_\_ Signature of Program Director: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

**MEMBERSHIP INFORMATION**

Your Resident / Trainee Membership includes a subscription to the *American Journal of Gastroenterology*. After completion of training, you will have an opportunity to transition to full Membership.

**PAYMENT INFORMATION**

Application Fee: \$25 (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: \_\_\_\_\_