



The New York State Society of Anesthesiologists, Inc.

110 East 40th Street, Suite 300, New York, NY 10016 USA | WEBSITE: www.nyssa-pga.org | EMAIL: hq@nyssa-pga.org
TELEPHONE: 212-867-7140 | FAX: 212-687-1005 | INTERNATIONAL: +00 followed by number

Resident Member Application

Date of application: _____

1. Name: _____ 2. Date of Birth: _____
LAST FIRST MIDDLE MM/DD/YY

3. Home Address (required). Is this your primary address? Yes No

NUMBER STREET CITY STATE ZIP CODE

4. Business Address (required). Is this your primary address? Yes No

COMPANY NAME DEPARTMENT

NUMBER STREET CITY STATE ZIP CODE

5. OFFICE TELEPHONE MOBILE TELEPHONE E-MAIL ADDRESS

6. State of Principal Professional activity (e.g., Florida): _____

7. Gender: Male Female 8. Medical Education: _____
SCHOOL

CITY STATE ZIP CODE COUNTRY YEARS DEGREE

9. Residency: _____
HOSPITAL DATE BEGUN PROPOSED TERMINATION DATE

10. Licensed to practice in: _____ / _____
STATE AND DATE STATE AND DATE

11. Certification by: ABA: _____ Other Certification: _____
DATE ABA I.D. NUMBER DATE NUMBER

12. Applicants Signature: _____

13. Payment Information If paying by credit card, your card will be charged upon approval of your application.
Note: Dues of \$50.00 must accompany application.

Please charge my: AMEX MC VISA

CREDIT CARD NUMBER EXPIRATION DATE (MM/YY)

CARD HOLDER NAME (PLEASE PRINT) SIGNATURE

TO BE COMPLETED BY COMPONENT SOCIETY SECRETARY

Approved as a(n) _____ member in good standing of the
CATEGORY

_____ Society of Anesthesiologists.
COMPONENT

DATE SECRETARY OF COMPONENT SOCIETY