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

Affiliate Member Application

Date of application: _____

1. **Name:** _____ (LAST / FIRST / MIDDLE) 2. **Date of Birth:** _____ (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:** _____ (LOCATION AND DATES)

10. **Licensed to practice in:** _____ (STATE AND DATE) , _____ (STATE AND DATE)

11. **Certification by:** ABA: _____ (DATE / ABA I.D. NUMBER) Other Certification: _____ (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 $347.50 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) _____ (CATEGORY) member in good standing of the

_____ (COMPONENT) Society of Anesthesiologists.

_____ (DATE) _____ (SECRETARY OF COMPONENT SOCIETY)