



# The Florida Vascular Society Associate Membership Application

Please Return Application and Application Fee of \$250.00 to  
The Florida Vascular Society, 400 Capital Circle, SE, Suite 18307,  
Tallahassee, Florida 32301  
(607) 754-2765 / Fax: (850) 907-1230

ARNP       PA       RN       RVT  
(Please check which allied health degree you are licensed under)

To the Executive Council of the Florida Vascular Society, I hereby make application for membership in the Florida Vascular Society.

Date of Application: \_\_\_\_\_

Physician with whom you practice: \_\_\_\_\_

### PERSONAL INFORMATION (please print or type)

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Gender:  Male  Female      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse Name: \_\_\_\_\_ Citizenship: \_\_\_\_\_

**Sponsoring Member of Florida Vascular Society: (Must have two sponsors).**

### MAILING INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at  OFFICE  HOME

Office Address \_\_\_\_\_ Home Address \_\_\_\_\_

Office City/State/Zip \_\_\_\_\_ Home City/State/Zip \_\_\_\_\_

Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Office FAX \_\_\_\_\_ Home FAX \_\_\_\_\_

Office Email Address \_\_\_\_\_ Home Email Address \_\_\_\_\_

### EDUCATION

School: \_\_\_\_\_ Date: \_\_\_\_\_

Educational or Research Experiences: (May Be Listed Separately) \_\_\_\_\_

Publications: (May Be Listed Separately) \_\_\_\_\_

**PRACTICE/HOSPITAL AFFILIATIONS**

Practice Name: \_\_\_\_\_

Hospital (Primary) \_\_\_\_\_

City: \_\_\_\_\_

2. Hospital (Secondary) \_\_\_\_\_

City: \_\_\_\_\_

**PROFESSIONAL AND SCIENTIFIC SOCIETIES**

\_\_\_\_\_  
\_\_\_\_\_

**FLORIDA LICENSING BOARD**

Florida License Number \_\_\_\_\_

Date Issued: \_\_\_\_\_

Licensing Board:  
\_\_\_\_\_

**PAY BY CREDIT CARD**

Amount Due: \$250.00

Name on Card: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Visa       Master Card       American Express

Amount: \_\_\_\_\_ Card #: \_\_\_\_\_ ~~XXXXXXXXXXXXXXXXXXXX~~

Signature: \_\_\_\_\_

*The endorsement, deposit or negotiation of an applicant's payment does not constitute admission into or acceptance of membership by the FVS. Payments received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a check refunding the amount submitted with the application.*

**REQUIRED ATTACHMENTS**

1. Two letters of recommendation from Florida Vascular Society members. One letter must be from the physician that you Practice with.
2. Copy of Florida License
3. Submit photo as JPEG file to be used in membership directory. (Minimum file size 300px wide.)

*I agree, if elected, to attend the meetings of the Society and to contribute by presentations and discussions.*

Signature: \_\_\_\_\_

Typed Name: \_\_\_\_\_

**SEND**