



**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: \$150.00

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

Visa       Master Card       American Express

Amount: \_\_\_\_\_ Card #: \_\_\_\_\_

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

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

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

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