American Medical Physicians and Surgeons Advancement Alliance
Excellence in Quality Medicine

AMPSAA Active Membership Application

The American Medical Physicians and Surgeons Advancement Alliance (AMPSAA) is a global medical platform dedicated to improving lives. The annual active membership fees are $175.00, which are due every January 1. Associate membership for residents and fellows is free for the duration of their residency or fellowship.

* Required

Information

First Name*: _____ Middle Initial: _____ Last Name*: _____

Date of Birth*: _____ Gender*: Male☐ Female☐

Medical Degree(s) (MD, FACS, PhD, Professor)*: _____

License Number*: _____

License State/Province/Country*: _____ Year Issued: _____

Title: _____

Office Address*: _____

City /State /Province*: _____ Country/Postal Code: _____

Office Telephone*: _____ Office Fax: _____

Home/Cell Telephone (for internal use only) : _____

Email Address*: _____

Website: _____

Medical Education and Training

Professional School Graduation Date*: _____

Professional School*: _____

American Medical & Plastic Surgery Aesthetic Association
Excellence in Quality Medicine

Board Certification

Are you Board Certified or Board Eligible?*: Yes☐ No☐

Previous or Current Board Certification*: _____

Specialty*: _____

Date of Most Recent Certification: _____

Resident or Fellow ONLY

Are you a Resident or a Fellow in training?: Resident in training☐ Fellow in training☐

Current Training Program Name: _____

Address of the Program: _____

Date Projected to Complete Training: _____

Supporting Documentation and Sponsorship

Please list the name(s) of the AMPSAA member(s) who referred you: _____

Has your medical license or hospital privileges ever been revoked, suspended or restricted?*
Yes☐ No☐

If yes, please provide details of the situation(s): _____

_____

_____

Are you aware of any current inquiry, investigation, complaint, or other proceeding that could result in the revocation, suspension, or restriction of your medical license?*: Yes☐ No☐

If yes, please provide details of the situation(s): _____

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American Medical & Plastic Surgery Aesthetic Association
Excellence in Quality Medicine

Application Submission

- I hereby certify that all information recorded on this application and any supporting documentation is accurate and supports my qualifications for membership in the American Medical Physicians and Surgeons Advancement Alliance, for which I now apply.*
  Yes☐ No☐
- I hereby agree that the American Medical Physicians and Surgeons Advancement Alliance may verify any data provided within this application. If elected, I agree to conform to all applicable policies and membership requirements of AMPSAA and uphold AMPSAA's Code of Ethics.*
  Yes☐ No☐
- To apply for membership, please email this completed application along with your CV and a high resolution headshot to membership@ampsaa.org
- I hereby agree that AMPSAA has my permission to communicate with me electronically via email.*
  Yes☐ No☐

Name and Likeness Authorization

I hereby acknowledge that by accepting admission as a member into the American Medical Physicians and Surgeons Advancement Alliance, a California nonprofit corporation ("AMPSAA"), I grant AMPSAA permission to use my name, photo, and information in a photograph, video, or other digital media ("photo") and in any and all of its publications, including web-based publications, without payment or other consideration. I hereby hold harmless, release, and forever discharge the AMPSAA from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

_____	_____	_____
Print Name*	**Signature***	**Date***

Please send the application to membership@ampsaa.org along with your CV and a high resolution headshot