American Medical Physicians and Surgeons Advancement Alliance
Excellence in Quality Medicine

AMPSAA Chinese Active Membership Application
美国医师促进协会中国会员申请表

The American Medical Physicians and Surgeons Advancement Alliance (AMPSAA) is a global medical platform dedicated to improving lives. The annual international active membership dues are $175, which are due every January 1. Associate membership for residents and fellows is free for the duration of their residency or fellowship.
美国医师促进协会(AMPSAA)是一个致力于改善健康与生命的全球性医疗平台。年度国际会员费为175 美元/年，每年 1 月 1 日缴纳。住院医师和研究员在其住院或研究期间为准会员资格，不收取会员费用。

Please fill out the application in English or Chinese.
请用英文或中文填写该申请表。

* Required 必填

Information 个人信息

First Name 姓*: _____ Last Name 名*: _____

Date of Birth 出生年月日*: _____

Gender 性别*: Male 男 ☐ Female 女 ☐

Medical Degree(s) (MD, FACS, PhD, Professor) 医学学位或职称（如医学博士、博士、教授等）*:

_____

Cell Phone (for internal use only) 手机号码（仅供 AMPSAA 内部使用）: _____

Email Address 电子邮箱*: _____

License Number 医疗执照或医师执业证书编码*: _____

License Authority 发证机关*: _____

Year Issued 发证日期*: _____

Hospital Name 所在医院*: _____

Hospital Address 医院地址*: _____

Current Department 所在部门*: _____ Title 职务*: _____

Department Chair's Name 部门主任*: _____

Department Chair's Phone 部门主任联系电话: _____

Department Chair's Email 部门主任电子邮箱: _____

Medical Education and Training 医学教育及培训

Professional School 医学院校*: _____

Professional School Graduation Date 医学院校毕业日期*: _____

Resident or Fellow ONLY 仅供住院医师或研究员填写

Are you a Resident or a Fellow in training? 您是正在接收培训的住院医师或研究员？: Resident in training 住院医师_____ Fellow in training 研究员_____

Current Training Program Name 目前正在接收的培训项目: _____

Address of the Program 项目地点: _____

Date Projected to Complete Training 培训预计完成日期: _____

Supporting Documentation and Sponsorship 相关支持材料

Please list the name(s) of the AMPSAA member(s) who referred you 请列出推荐您加入协会的人员名字: _____

Has your medical license or hospital privileges ever been revoked, suspended or restricted? 您的医疗执照或行医资格是否曾经被吊销、暂停或限制?* Yes 是☐ No 否☐

If yes, please provide details of the situation(s) 如果是，请详细说明情况: _____

_____

_____

_____

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? 您是否正在接受任何可能导致您的医疗执照被撤销、暂停或限制的调查、投诉或其他诉讼？* : Yes 是☐ No 否☐

If yes, please provide details of the situation(s) 如果是，请详细说明情况: _____

_____

_____

Application Submission 提交申请

- 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. 我在此声明，此申请表上提供的所有信息和任何支持性文件都是准确的，并可成为我申请加入美国医师促进协会(American Medical Physicians and Surgeons Advancement Alliance)的资格证明。*
  Yes 是☐ No 否☐

- 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. 我在此同意，美国医师促进协会(American Medical Physicians and Surgeons Advancement Alliance)可以核实申请表中提供的任何信息和数据。如果会员资格生效，我同意遵守 AMPSAA 的所有适用政策和会员要求，并遵守 AMPSAA 的职业道德准则。*
  Yes 是☐ No 否☐

- I hereby agree that AMPSAA has my permission to communicate with me electronically via email. 我在此同意 AMPSAA 有权通过电子邮件与我进行联系与沟通。 *
  Yes 是☐ No 否☐

- To apply for membership, please submit this completed application along with your CV, a high resolution headshot and a letter of recommendation from your hospital to verify your job title and performance quality in your institution. After submission, you may be asked for additional supporting documentation. 申请成为会员，请将填妥的申请表连同简历、高清头像照片以及一份证明您职务和工作表现的医院推荐信一并提交。之后，您可能会被要求提交其他的支持材料。

Name and Likeness Authorization 姓名及肖像授权

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.

我在此承认，作为美国加州非盈利机构-美国医师促进协会（American Medical Physicians and Surgeons Advancement Alliance，缩写 AMPSAA）的会员，授权 AMPSAA 可以在图片、视频、其他数字格式的电子媒介和任何出版物（包括网络出版物）中无偿且无条件使用我的名字、照片和相关信息。对于任何因该授权而由我本人、我的继承人、个人代表、执行人、管理人、以及任何其他代表我本人或我本人财产的行事人员所提出的任何赔偿、要求和诉讼等，我对 AMPSAA 永不追究任何责任。

_____	_____	_____
Print Name 姓名正楷*	**Signature 签名***	**Date 日期***

Please send the application to **membership@ampsaa.org** along with your CV, a high resolution headshot and a letter of recommendation from your hospital to verify your job title and performance quality in your institution.
请将该申请表连同您的简历、高清头像照片以及一份证明您职务和工作表现的医院推荐信一并发送至 membership@ampsaa.org