



Association of Women Surgeons

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INSTITUTIONAL MEMBERSHIP APPLICATION

Institutional Membership is available per institution. Each membership includes an unlimited number of AWS memberships for the women residents and fellows enrolled in your residency program, advertising on the web site for faculty positions, and all other AWS member benefits. Please complete this application and return it with payment to enroll your residents in a professional network of over 1700 women surgeons.

Institutional Contact:

First Name: _____ Last Name: _____ M.D. D.O. FACS

Title: _____

Affiliation: _____

Address: _____

City: _____ State/Province: _____ Zip/Postal Code: _____

Country: _____ Phone: _____

Fax: _____ Email: _____

Complete the registration information found on the reverse of this page for each resident covered under your institutional membership.

- Institutional Membership *(based on number of Residents enrolled)* →
 - 1-20 Residents - \$500
 - 21+ Residents - \$750
- I would like to make an additional contribution to the AWS Foundation: \$100 \$500 \$1000 Other →
- *American Journal of Surgery (AJS)* subscriptions at the special reduced rate of →
 - \$50 per year for U.S. residents x ____ residents = _____
- Missionary members are unable to afford a membership. Indicate your intent to help **sponsor a missionary membership**. (Suggested donation is \$100.) →

Payment Information	
	AMOUNT
Membership	\$ _____
Foundation Contribution	\$ _____
AJS Subscriptions	\$ _____
Missionary Sponsor	\$ _____
TOTAL AMOUNT ENCLOSED	\$

Method of Payment: *(Checks should be payable to AWS)*

Return this application to the AWS Office via fax or mail.

Check Visa MasterCard American Express

Credit Card Number: _____ Exp. Date: _____

Signature: _____ Zip code of billing address: _____
(Signifies authorization to charge credit card)

(over)

Please complete the following information for the women residents in your program who will be covered under your institutional membership. Copy this page if additional space is needed.

(Note member publications are electronically dispersed.)

Resident: _____

Send mail to: Institution listed on front of application
 Work/Home as listed below

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

E-mail: _____

(Necessary to receive member publications)

Optional

Surgical Specialty: _____

Medical School: _____

Year Graduated: _____

Surgical Residency: _____

Fellowship: _____

AWS membership provides an opportunity to subscribe to the American Journal of Surgery (AJS) at the special reduced rate of \$50 per year for U.S. residents. Indicate a subscription for each resident.

AJS Subscription

Resident: _____

Send mail to: Institution listed on front of application
 Work/Home as listed below

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

E-mail: _____

(Necessary to receive member publications)

Optional

Surgical Specialty: _____

Medical School: _____

Year Graduated: _____

Surgical Residency: _____

Fellowship: _____

AJS Subscription

Resident: _____

Send mail to: Institution listed on front of application
 Work/Home as listed below

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

E-mail: _____

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AJS Subscription

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Fellowship: _____

AJS Subscription

Total number of AJS Subscriptions (add to front): _____