Affiliate Member Application

Date of application: _____

Name: _____ **Date of Birth:** _____
(Last) (First) (Middle)

Home Address: _____ **Is this your primary address?** ☐ Yes ☐ No

City: _____ State: _____ Zip Code: _____

Business Address: _____ **Is this your primary address?** ☐ Yes ☐ No

Company Name: _____ Department: _____

City: _____ State: _____ Zip Code: _____

*Personal E-mail: _____ ☐ Do Not Display

*Work E-mail: _____ ☐ Do Not Display

*Phone: _____ ☐ Do Not Display *Cell: _____ ☐ Do Not Display

* *Unless indicated in the "Do Not Display" box, this information will be included in your online directory listing that can be viewed by other TSA members.*

Preferred E-mail: ☐ Personal ☐ Work Preferred Phone #: ☐ Phone ☐ Cell

Primary Place of Practice *(e.g., Hospital)*: _____ **Gender:** ☐ M ☐ F

Hospital Address: _____ Suite No: _____

City: _____ State: _____ Zip Code: _____ Years: _____ Degree: _____

Medical School : _____
(Location and Dates)

Internship: _____ **Residency:** _____
(Location and Dates) (Location and Dates)

Texas Medical License: _____ **Certification by:** ABA: _____
(State and Date) (Date) and (8-digit ABA I.D. #)

Applicants Signature: _____ **Date:** _____

For Physicians In Full-Time Military Service

If you are active duty military personnel and/or joining the USSA (Uniformed Services Society of Anesthesiologists) component, please make sure to complete this section.

Rank: _____

Duty Station: _____ Branch: _____

Payment Method

Note: Annual Dues are $200.00 must accompany application; the prorated amount is adjusted by approval month.

If paying by credit card, your card will be charged upon approval of your application.

Please contact TSA Member Services at (512) 370-1659 with any questions. ***Dues are based on the calendar year.***

☐ American Express ☐ MasterCard ☐ VISA ☐ Discover ☐ Check (Payable to Texas Society of Anesthesiologists)

Credit Card Number: _____

Expiration Date: _____ (month/year) CVV/CVC: _____ (3 or 4 Digits) Card Holder Name: _____ (please print)

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Signature _____

MEMBERSHIP IN GOOD STANDING OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS
REQUIRES ADHERENCE TO THE ASA "GUIDELINES FOR THE ETHICAL PRACTICE OF ANESTHESIOLOGY."

Email completed form to:
Texas Society of Anesthesiologists
info@tsa.org

Or fax to:
Attn: Membership
(512) 370-1655

Applications are processed on the 15th of each month.

TO BE COMPLETED BY COMPONENT SOCIETY SECRETARY

Approved as a(n) _____ (Category) member in good standing of the

_____ (Component) Society of Anesthesiologists.

_____ (Date) _____ (Secretary of Component Society)