Application for Anesthesiologist Assistant Membership

PERSONAL INFORMATION *(Please print or type)*

Name: ____________________ Date: __________
(Full Legal Name)

Date of Birth: ____________________ Gender: ☐ Male ☐ Female

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

Training Program: ____________________

Current Appointment: ____________________ Suite No: __________

☐ I agree with the "Guidelines for the Ethical Practice of Anesthesiology" and subscribe to the "Anesthesia Care Team" statement, as provided within this application.

Applicant's Signature: ____________________ **Date:** __________

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.

Payment Method

Note: Educational Dues of $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."

TO BE COMPLETED BY COMPONENT SOCIETY SECRETARY

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

______________________________ Society of Anesthesiologists.
(Component)

____________________ ______________________________
(Date) (Secretary of Component Society)