



SAGES

Society of American Gastrointestinal and Endoscopic Surgeons

APPLICATION FOR **AFFILIATE** MEMBERSHIP

SAGES Membership Services
11300 W Olympic Blvd #600
Los Angeles CA 90064
Phone: 310-437-0544
Fax: 310-424-3398
Email : membership@sages.org
Web Site : www.sages.org

AFFILIATE MEMBERSHIP REQUIREMENTS:

- This membership category is appropriate for Nurses, RNFAs, Nurse Practitioners, Physician Assistants, Surgical Educators, Engineers, and others devoted to a career in healthcare and actively participating in the practice of, or research in, endoscopic or minimal access surgery.

Application Date: _____

Please check: Male Female I choose not to disclose

PLEASE TYPE OR PRINT CLEARLY

APPLICANT'S FULL NAME:

(LAST/FAMILY NAME)

(FIRST/GIVEN NAME)

(MIDDLE NAME OR INITIAL)

MD PhD RN BSN LPN CNRP MA NP PA-C Other Degrees: _____

Professional Title: _____ Primary Health Specialty: _____

Date of Birth (month/day/year): _____ Country of Birth: _____

PLEASE CHECK PREFERRED MAILING ADDRESS:

PROFESSIONAL ADDRESS:

(Company or Organization or Institution)

(Department)

(Street Address) (Suite or Room or Building or PO Box)

(City) (State/Province) (Zip/Postal Code) (Country)

(Business Phone Number) (Business E-Mail Address)

RESIDENCE ADDRESS:

(Street Address) (Apt Number or Box Number)

(City) (State/Province) (Zip/Postal Code) (Country)

(Home or Cell Phone Number) (Personal E-Mail Address)

EDUCATION (COMPLETE ANY APPLICABLE TO YOUR EDUCATION):

College/University: Institution	Degree	Date Awarded
Medical/Nursing School: Institution	Degree	Date Awarded
Other Applicable Training: Institution	Degree	Date Awarded

MEDICAL LICENSURE:

Issuing Body	Registry Number	Expiration Date
<input type="checkbox"/> A license is not issued in my profession.		
Has your medical license ever been suspended or revoked in any state?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have your privileges ever been suspended or changed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

BOARD CERTIFICATION:

A certificate is not issued in my profession.

I am Board certified by: _____ Certificate #: _____ Expiration Date: _____

Current job position description: _____

Why do you want to join SAGES? _____

Who referred you to SAGES? _____

AUTHORIZATION: I authorize the Society of American Gastrointestinal and Endoscopic Surgeons to obtain information from societies, hospital staffs, members and any other source regarding this application and my qualifications for membership that will be kept confidential by the Society.

Applicant's Signature: _____

SPONSOR:

Current Sages Member: _____ Email: _____

CHECKLIST FOR REQUIRED DOCUMENTS TO COMPLETE APPLICATION:

- A signed, fully completed application form (or complete an online application at <https://www.sages.org/membership/affiliate/>)
- A letter of recommendation from a current Active SAGES member in good standing

APPLICATION REVIEW PROCESS: The SAGES Membership Committee meets quarterly, in January, March/April, July, and October, to consider new members. Applications must be complete one month prior to final approval meeting dates.

ANNUAL MEMBERSHIP DUES: Annual dues for Affiliate members are \$150 and includes an online subscription to the *Surgical Endoscopy* journal. Dues are invoiced AFTER acceptance into membership. **(No application fee is required).**