



SAGES

Society of American Gastrointestinal and Endoscopic Surgeons
APPLICATION FOR **ASSOCIATE ACTIVE** 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

ASSOCIATE ACTIVE MEMBERSHIP REQUIREMENTS:

- Practice within the United States, Canada or Puerto Rico.
- License to practice medicine in his/her state, province or country. Applicant may be in government service not requiring licensure.
- Certification by an American Surgical Specialty Board (other than the American Board of Surgery, the American Board of Osteopathic Surgery, fellowship in the Royal College of Surgeons, Canada, or fellowship in the American College of Surgeons) that is a member of the American Board of Medical Specialties and appropriate to applicant's specialty practice, or certification in gastroenterology by the American Board of Internal Medicine, or appropriate equivalent specialty certification by the Royal College of Physicians and Surgeons of Canada.

PLEASE TYPE OR PRINT CLEARLY Application Date: _____

Please check: Male Female I choose not to disclose

APPLICANT'S FULL NAME:

(LAST/FAMILY NAME) (FIRST/GIVEN NAME) (MIDDLE NAME OR INITIAL)

MD PhD Other Degrees: _____

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

PLEASE CHECK PREFERRED MAILING ADDRESS:

PROFESSIONAL ADDRESS:

(Company or Organization or Institution)

(Department) (Title)

(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:

College/University: Institution _____	Degree _____	Date Awarded _____
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Medical School: Institution _____	Degree _____	Date Awarded _____
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Postgraduate Training: Institution _____	Degree _____	Date Awarded _____
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Internship: Institution _____	Program Director _____	Inclusive Dates _____
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Residency: Institution _____	Program Director _____	Inclusive Dates _____
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Fellowship: Institution _____	Program Director _____	Inclusive Dates _____
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Other: Institution _____	Program Director _____	Inclusive Dates _____
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MEDICAL LICENSURE:

State _____	Registry Number _____	Expiration Date _____
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Has your medical license ever been suspended or revoked in any state? Yes No

Have your privileges ever been suspended or changed? Yes No

BOARD CERTIFICATION:

<input type="checkbox"/> Certified by an American Surgical Specialty Board	Certificate #: _____	Specialty: _____
<input type="checkbox"/> Certified by the American Board of Internal Medicine	Certificate # _____	Specialty: _____
<input type="checkbox"/> Certified by the Royal College of Physicians and Surgeons of Canada	Certificate # _____	Specialty: _____

FELLOWSHIPS and MEMBERSHIPS:

AMA ASGE AUA ASCRS AAGL AWS SBAS Other _____

CURRENT ENDOSCOPIC/LAPAROSCOPIC EXPERIENCE (NOT NECESSARY TO HAVE EXPERIENCE IN ALL THESE PROCEDURES):**FLEXIBLE GI ENDOSCOPY****(Approximate # Past 12 months/3 years/Complications)**

EGD # ___ / # ___ / # ___
 ERCP # ___ / # ___ / # ___
 PEG # ___ / # ___ / # ___
 COLONOSCOPY # ___ / # ___ / # ___

 OTHER _____**LAPAROSCOPIC GENERAL SURGERY****(Approximate # Past 12 months/3 years/Complications)**

LAPAROSCOPY # ___ / # ___ / # ___
 LAPAROSCOPIC CHOLECYSTECTOMY # ___ / # ___ / # ___
 LAPAROSCOPIC CHOLEDOCHOSCOPY # ___ / # ___ / # ___
 UPPER GI LAPAROSCOPIC SURGERY # ___ / # ___ / # ___
 LOWER GI LAPAROSCOPIC SURGERY # ___ / # ___ / # ___
 LAPAROSCOPIC SOLID ORGAN REMOVAL # ___ / # ___ / # ___

ENDOSCOPIC and LAPAROSCOPIC TRAINING:

Is/Was **FLEXIBLE ENDOSCOPY** included in your surgical residency or fellowship training? Yes No

If yes, who is/was your Endoscopic Instructor? _____ Inclusive Dates: _____

Endoscopic Instructor? _____ Inclusive Dates: _____

Endoscopic Instructor? _____ Inclusive Dates: _____

Is/Was **LAPAROSCOPIC SURGERY** included in your surgical residency or fellowship training? Yes No

If yes, who is/was your Instructor? _____ Inclusive Dates: _____

Instructor? _____ Inclusive Dates: _____

Instructor? _____ Inclusive Dates: _____

ACADEMIC APPOINTMENTS (BEGIN WITH CURRENT):

_____	_____	_____	<input type="checkbox"/> CLINICAL? <input type="checkbox"/> FULL TIME?
Institution	Title	Inclusive Dates	
_____	_____	_____	<input type="checkbox"/> CLINICAL? <input type="checkbox"/> FULL TIME?
Institution	Title	Inclusive Dates	
_____	_____	_____	<input type="checkbox"/> CLINICAL? <input type="checkbox"/> FULL TIME?
Institution	Title	Inclusive Dates	

HOSPITAL APPOINTMENTS (BEGIN WITH CURRENT):

_____	_____
Institution	Inclusive Dates
_____	_____
Institution	Inclusive Dates
_____	_____
Institution	Inclusive Dates

PRACTICE PATTERNS (INDICATE YOUR SURGICAL PRACTICE AS IT IS NOW DEFINED):

- | | | | |
|--|---|---|-----------------------------------|
| <input type="checkbox"/> Private Practice Solo | <input type="checkbox"/> Private Practice Group | <input type="checkbox"/> Private Practice/Part Time HMO | <input type="checkbox"/> Military |
| <input type="checkbox"/> Full Time HMO or IPA | <input type="checkbox"/> Full Time Academic | <input type="checkbox"/> Full Time Government (VA) | <input type="checkbox"/> Other |

I consider myself primarily to be:

- | | |
|---|---|
| <input type="checkbox"/> Academic Surgeon | <input type="checkbox"/> Community Practice Surgeon |
|---|---|

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: _____

SPONSORS:

Current SAGES Member: _____ Email: _____

Program Director: _____ Email: _____

CHECKLIST FOR REQUIRED DOCUMENTS TO COMPLETE APPLICATION:

- A signed, fully completed application form (or complete an online application at www.sages.org)
- A copy of your current medical license
- A copy of your certificate from an American Surgical Specialty Board, the American Board of Internal Medicine, the American College of Surgeons or the Royal College of Surgeons
- Documented experience in minimal access surgery (e.g., endoscopy, laparoscopy, thoracoscopy, robotics) in a surgical field other than gastrointestinal surgery, or documented recognition and expertise in advanced therapeutic gastroenterologic endoscopy, by applicant dedicated to goals and objectives of the Society

TWO letters of recommendation from two sponsors describing applicant's competency in the field of minimal access surgery:

- A letter from a current SAGES member. (or request an introduction by emailing membership@sages.org)
- A letter from the Chief/Chair of Surgery/ Chief of Staff, or applicant's Program Director/instructor in endoscopy or laparoscopy, or a physician familiar with your practice
- Application fee of \$100

PROMO CODE: _____

PLEASE FIND ENCLOSED MY \$100 USD APPLICATION FEE:

- A check (USD only) is enclosed with this application. Please make checks payable to SAGES.

- I authorize you to charge my:    

CC Number: _____ Expiration Date: _____ Code: _____ Amount: _____

Cardholder Name: _____ Signature: _____

or remit payment online at: <https://www.sages.org/sages-membership-application-fee/>

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 Associate Active members are \$350 and includes your online subscription to the *Surgical Endoscopy* journal. Dues are invoiced AFTER acceptance into membership.