West Virginia State Society of Anesthesiologists

Department of Anesthesiology, PO Box 8255, Morgantown, WV 26506
Robert Johnstone, MD, WVSSA Secretary - Treasurer
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_______________ (Date of application)

1. I hereby make application for (circle one) **ACTIVE AFFILIATE RESIDENT RETIRED** membership
2. Name: _______________ (Last) (First) (Middle) 3. Date of Birth: _______________ (Month) (Day) (Year)
4. **Home Address:** Is this your primary mailing address? ___ Yes ___ No

_______________ (Number) (Street)

_______________ (City) (State) (Zip Code) (Country)

Business Address: Is this your primary mailing address? ___ Yes ___ No

_______________ (Company Name) (Department)

_______________ (Number) (Street)

_______________ (City) (State) (Zip Code)

Billing Address for ASA Dues Statement: **If not completed, statement will be sent to Primary Mailing Address**

_______________ (Company Name – if applicable) (Department – if applicable)

_______________ (Number) (Street)

_______________ (City) (State) (Zip Code)

Office Telephone* _______________

Office Fax Number* _______________

E-Mail Address* _______________

Dues
Active $220
Resident Free
Include payment with application

5. Location of Principal Professional activity: _______________
6. Gender: ____ M ____ F
7. Medical Education: _______________ (School) (City) (State) (Country) (Years) (Degree)
8. Internship: _______________ (Location and Dates)
9. Residency: _______________ (Location and Dates)
10. Licensed to practice in: _______________ (State and Date), _______________ (State and Date)
11. Previous membership in ASA or Component Society: _______________ (Society and Dates)
12. Certification by: ABA _______________ (Date) (Number) Other _______________ (Date) (Number)
13. Present Appointments: _______________ (Indicate Institutions and Dates)
14. _______________ **(APPLICANT'S SIGNATURE)**