New England Society of Anesthesiologists

(A Society for Physicians with an Interest in Anesthesiology)

Membership Application

*Items with *are required information*

1. **I am completing this form for:** **Date:**_________________

☐ New Application ☐ Current Member Update/Correction

II. **Name ***
Last Name: _________________ First Name: _________________ Middle Initial _________

III. **Degree ***
☐ MD ☐ DO ☐ Other (list) _________________________________

IV. **Professional Mailing Address:**

Hospital/Clinic: ____
Department: ____
Street Address:____
City: _______________________________ State: ___________ Zip:________________
Office Phone (with area code): ___________________________ Fax: _____________________

V. **Home Mailing Address*:**

Street Address: ____
City: _______________________________ State: ___________ Zip: ________________
Home Phone (with area code): ____________________________ Cell: _____________________

VI. **Licensure*:**
Licensed to Practice Medicine in: (State) ____________________

VII. **Email:** ____

VIII **Comments:**

IX, **Signature:** ____ **Date:** ____________________

Please complete this form and submit by Mail, with check (payable to NE Society of Anesthesiologists) for $50

James Gessner, M.D., Secretary/Treasurer
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