



RESIDENT/STUDENT MEMBERSHIP APPLICATION

INSTRUCTIONS TO APPLICANTS FOR RESIDENT/MEDICAL STUDENT MEMBERSHIP

QUALIFICATIONS

Resident and Medical Student Membership shall be reserved for physicians or students currently enrolled in a US or international residency or medical school.

NOMINATION AND ELECTION:

Nomination and election shall be according to procedures established by the SGO council.

PRIVILEGES:

- i) May not serve on committees;
- ii) May not sponsor candidates for membership;
- iii) May not vote or hold elective office.

All candidates must provide verification of enrollment from the applicant's program director or faculty advisor. Membership is terminated upon graduation.

INSTRUCTIONS

1. Complete the enclosed application form and attach the following:
 - i) Passport size photograph.
 - ii) Verification of enrollment from Program Director/Faculty Advisor.
 - iii) Only completed applications will be accepted.
 - iv) Dues in the amount of \$25.00 (USD) will be invoiced upon membership approval.
2. **Failure to follow these guidelines exactly will cause your application to be returned in order to obtain compliance, and may delay approval of your application.**
3. **Main deadline: July 31st**
Applications are accepted throughout the year as needed
4. Send completed applications by to:
**Society of Gynecologic Oncology
230 W. Monroe Street, Suite 710
Chicago, IL 60606-4703 USA**

or e-mail to: membership@sgo.org

PERSONAL INFORMATION

Name	
Gender <input type="radio"/> Male <input type="radio"/> Female	Date of Birth
Place of Birth	
Citizenship	
Title	
Institution	
MAILING ADDRESS (home address recommended)	
<input type="radio"/> Work <input type="radio"/> Home	
Street	
City	
State/Province	
Country	Postal Code
Phone Number (Country Code + City Code + Number)	
Mobile	
FAX (Country Code + City Code + Number)	
Email	
Countries Where Licensed	

MEDICAL SCHOOL AFFILIATION

Evidence of Membership

PROFESSIONAL INFORMATION

STATEMENT
Please describe why you are seeking membership in the SGO

PROFESSIONAL DESIGNATION

MD DO MBBS PhD
 RN PA-C Other _____

PROFESSIONAL QUALIFICATIONS

University/College

Degree	Date
School	
Degree	Date
Residency	
Degree	Date
Residency Program Type/Specialty	

PROGRAM DATES

Start Date

Expected Completion Date

PROGRAM DIRECTOR/FACULTY ADVISOR USE ONLY

VERIFICATION OF PROGRAM ENROLLMENT

Name

Signature

In furtherance of my application for membership in the Society of Gynecologic Oncology (SGO), I hereby authorize the evaluation and validation of my credentials by SGO in accordance with and subject to the rules and procedures of the SGO.

I request and authorize any hospital, medical staff, medical organization or individual who may have information (including, but not by way of limitation, medical records, patient records, and reports of committees) which they deem relevant to my fitness for membership in SGO to provide such information to SGO.

I hereby release from liability and waive any claim for damages that I may have against SGO, its officers, directors, members, employees and agents for any acts that they may perform in good faith in connection with my application, and any hospital, medical staff, medical organization or individual supplying information with respect to my application.

I understand that the decision as to whether I am qualified to be submitted to SGO membership for election rests solely and exclusively in the SGO Council, and that its decision is final.

I attest that the information presented in this application is truthful and accurate.

Please place photograph here

Signature	Date
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PAYMENT METHOD	
<input type="radio"/> Check Enclosed payable to SGO	Please charge my Credit Card <input type="radio"/> Visa <input type="radio"/> MasterCard <input type="radio"/> American Express
Name as it appears on card	
Card Number:	
Card Security Code	Expiration Date (MM/YY)
<input type="radio"/> I authorize the use of my credit card for the following charges. <input type="radio"/> Application Fee \$25.00 USD	
Card Holder Signature	Date

CREDIT CARD BILLING ADDRESS	
Street	
City	
State/Province	
Country	Postal Code

If you are submitting this form electronically, please attach a digital photo to the e-mail when sending.

