

Membership Application

Personal Data:

Names:
(Last/Family) (First) (Middle)

Office Address:

Office Phone: Fax:

e-mail:

Residence Address:

Residence Phone: Fax:

Date of Birth: Place of Birth :

Citizenship:

Marital Status: Name of Spouse :

EDUCATION

University:

Degree: Year:

Internship, Residency, Fellowship etc., List in chronological order : (ev. add separate sheet)

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MEDICAL LICENSE List countries where you are licensed to practice medicine

.....
(Country) (License #) (Date License issued)

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(Country) (License #) (Date License issued)

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(Country) (License #) (Date License issued)

Has your license to practice in any jurisdiction ever been limited, suspended or revoked ?

Yes/No : If so, attach explanatory letter.

Has any hospital reduced, restricted, suspended, terminated or requested you to resign all or any position of your staff privileges or any such actions pending against you at the present time ?

Yes/No : If so, attach explanatory letter.

References

Please list two orthopaedic surgeons or neurosurgeons or physicians in your particular field of medicine who are familiar with your work and request that they forward their recommendation directly to the ISMISS offices.

.....
(Name and Address)

.....
(Name and Address)

Certification

National Board of Orthopaedic Surgeons
(Country) (Date Issued)

National Board of Neurosurgeons
(Country) (Date Issued)

