



# Chicago Dermatological Society

10 W. Phillip Rd., Suite 120 ❖ Vernon Hills, IL 60061-1730  
 (847) 680-1666 ❖ Fax: (847) 680-1682 ❖ Email: RichardPaul@dls.net

## Membership Application

Please provide the information requested below and return with the your application fee to:  
*Chicago Dermatological Society, 10 W. Phillip Rd., Suite 120, Vernon Hills, IL 60061.*  
 All applications must be nominated by a current members (see signature box below).

**\*\*\* Please complete BOTH pages of application. \*\*\***

**Application fee: \$150.00** (must accompany application; **waived for graduating residents in their first year of practice**) – see back page for details on categories of membership

**PLEASE PRINT**

|   |   |
|---|---|
| <b>Applicant's name</b> <i>enter here</i>               | _____   |
| <b>Degree(s) - check all that apply</b>                 | <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PhD <input type="checkbox"/> Other_____                            |
| <b>Membership Category</b> (check one)                  | <input type="checkbox"/> Regular <input type="checkbox"/> Affiliate<br><input type="checkbox"/> Non-resident <input type="checkbox"/> Corresponding |
| <b>PRACTICE INFORMATION</b>                             |   |
| Practice Name   | _____   |
| Office Mailing address                                  | _____   |
| City/State/Zip  | _____   |
| Office phone  | _____   |
| Office fax  | _____   |
| <b>HOME INFORMATION</b> <i>(will not be published)</i>  |   |
| Street  | _____   |
| City/State/Zip  | _____   |
| Home phone  | _____   |
| <b>Preferred mailing address:</b><br><i>(check one)</i> | <input type="checkbox"/> Office <input type="checkbox"/> Home   |
| <b>Preferred Email</b> <i>(very important!)</i>         | _____   |
| <b>NOMINATED BY</b> <i>(must be current member)</i>     |   |
| <i>Print name of member</i>                             | <i>Member's signature</i>   |
| _____   | _____   |

*Continued on next page*

### For Office Use Only

|                             |       |       |
|-----------------------------|-------|-------|
| Date received               | _____ | _____ |
| Application fee paid        | _____ | _____ |
| Membership Committee review | _____ | _____ |
| Plans & Policies review     | _____ | _____ |
| Announced - business mtg    | _____ | _____ |
| Final approval              | _____ | _____ |

## BACKGROUND INFORMATION

PLEASE PRINT

|   |  |
|---|--|
| Date of birth   |  |
| Illinois medical license number   |  |
| Board certification & date  |  |
| Education (Undergraduate/Graduate)<br>List School(s), Degree(s) and Year(s)   |  |
| Medical school & year graduated   |  |
| Residency<br>Specialty(s)<br>Location<br>Dates (years)  |  |
| Fellowship(s) completed<br>Subspeciality<br>Location<br>Dates   |  |
| Academic Appointments<br>School(s)<br>Position(s)   |  |
| If not practicing dermatology and your application is for other than "Regular" member, describe activities and duration related to dermatology: |  |
|   |  |

**Amount enclosed:** \$ \_\_\_\_\_

**Form of Payment:**     Check (payable to "Chicago Dermatological Society")     Visa     MasterCard

Credit Card # | | | | ■ | | | | ■ | | | | ■ | | | |    Exp. Date | | / | | | |  
 Security Code (on back of card) | | | | |

Name on card: \_\_\_\_\_

Signature \_\_\_\_\_

Send application along with application fee check or credit card information to:  
 Chicago Dermatological Society  
 Administrative Office  
 10 W. Phillip Rd., Suite 120  
 Vernon Hills, IL 60061-1730