



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 ♦ Web: www.ChicagoDerm.org

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: \$300.00 (\$200 for recent graduates in their first two years of practice) applied to first year of dues for Chicago Dermatological Society and Illinois Dermatological Society. See information sheet for details on member categories and annual dues rates.

PLEASE PRINT

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(will not be published)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

Continued on next page

Sept 2013

<i>For Office Use Only</i>		
Date received	_____	_____
Application fee paid	_____	_____
Membership Committee review	_____	_____
Plans & Policies review	_____	_____
Announced - business mtg	_____	_____
Final approval	_____	_____

BACKGROUND INFORMATION

PLEASE PRINT

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

Please finish by completing the payment information on the next page . . .

