

SLS MEMBERSHIP APPLICATION

FIRST NAME _____ LAST NAME _____

DEGREE _____

ADDRESS _____

CITY _____ STATE (PROVINCE) _____

ZIP CODE _____

COUNTRY _____

PHONE _____ FAX _____

E-MAIL _____

PRACTICE WEB SITE _____

UNDERGRAD _____ DEGREE _____ YEAR _____

MEDICAL SCHOOL _____ DEGREE _____ YEAR _____

POSTGRADUATE TRAINING _____ DEGREE _____ YEAR _____

OTHER _____

TYPE OF PRACTICE (CHECK ONE)

- General Surgery Ob-Gyn Urology
 Other _____

HOSPITAL AFFILIATIONS _____

OTHER MEDICAL SOCIETIES _____

BOARD CERTIFICATION _____

ANNUAL DUES (CHECK ONE)

- Physician (\$250) Fellow (\$75)
 Resident (\$75) Retired Physician (\$75)
 Nurse/Technician (\$75)

PAYMENT OPTIONS (CHECK ONE)

- Check Enclosed
 Visa _____
 Mastercard _____

EXP DATE _____ SIGNATURE _____

Please send application and annual dues, in US funds to:
SOCIETY OF LAPAROENDOSCOPIC SURGEONS
7330 SW 62 Place, Suite 410 • Miami, FL 33143-4825, USA
TEL: (305) 665-9959 • (800) 446-2659 • FAX: (305) 667-4123
E-MAIL: Membership@SLS.org • WEB SITE: www.sls.org