



**Application for Membership**  
World Society  
For  
Reconstructive Microsurgery

Attach  
Recent  
Photograph

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**Personal Data**

(please TYPE name exactly as you wish it to appear on your certificate)

Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Research Address (if applicable): \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

DAY MONTH YEAR

Citizenship: \_\_\_\_\_ Name of Wife/Husband: \_\_\_\_\_

Present Position: \_\_\_\_\_

Institution: \_\_\_\_\_

**Professional Qualifications**

Pre-medical School: \_\_\_\_\_ Degree/Date \_\_\_\_\_

Medical School: \_\_\_\_\_ Date \_\_\_\_\_

Internship \_\_\_\_\_ Date \_\_\_\_\_

Residency \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_



**Present Professional Activities**

How long have you been in practice (after Fellowship)? \_\_\_\_\_

In present location? \_\_\_\_\_

Number of operations performed last year? \_\_\_\_\_

How many of these were Microneurovascular cases? \_\_\_\_\_

Please enclose a typewritten list of all microneurovascular operative procedures performed during the past year including date, hospital chart number, and patient’s initials.

Please enclose a typewritten list of all research activities, relevant publications to microneurovascular surgery and sources of funding.

**Sponsors**

A sponsor is required for all new membership applications. The sponsor must be an active member of the World Society of Reconstructive Microsurgery. The sponsor must write a letter, addressed to the Secretary General, supporting your application.

\_\_\_\_\_  
Sponsor Name (print or type)

\_\_\_\_\_  
Signature and Date

\_\_\_\_\_  
Address

Other letters of recommendation from those familiar with your professional activities are welcomed. The committee is particularly interested in receiving letters from chiefs of service of the hospitals, clinics, and universities where you trained and work.

Forward the completed application and requisite enclosures to:

World Society for Reconstructive Microsurgery  
Central Office – Attn: Krista Greco  
20 North Michigan Avenue, Suite 700  
Chicago, IL 60602 USA  
FAX 1-312-782-0553  
Email [centraloffice@wsrm.net](mailto:centraloffice@wsrm.net)

Please enclose with your membership application credit card billing information or a certified check in US Funds for the amount of \$100.00; made payable to the World Society for Reconstructive Microsurgery

Please charge my  Visa  MasterCard Card No. \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CID Code: \_\_\_\_\_ Name as it appears on Card: \_\_\_\_\_

Credit Card Billing Address: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_