Application for Membership
Chicago Society for Surgery of the Hand (CSSH)

Applicant Name:_____ Date:____/____/____

E-mail Address 1:_____ For official CSSH correspondence
E-mail Address 2:_____

Practice Name:_____
_____

Practice Address - Primary:_____ If you prefer CSSH to send
_____ communications and inquires to
_____ this address, mark here ☐

Home Address:_____ If you prefer CSSH to send
_____ communications and inquires to
_____ this address, mark here ☐

EDUCATION

- Undergraduate School

Name:_____
City and State:_____
Degree:_____
Date of Graduation:_____

- Graduate School (If Applicable)

Name:_____
City and State:_____
Degree:_____
Date of Graduation:_____

- Medical School

Name:_____
City and State:_____
Degree:_____
Date of Graduation:_____

- Residency Program

Field of Training (Orthopedic, Plastic, or General Surgery):
_____

Training Program:_____
City and State:_____
Program Director:_____
Dates: From_____ To_____

- Hand Surgery Fellowship:

Training Program:_____
Program Director:_____
Dates: From_____ To_____

BOARD CERTIFICATION

American Board of_____
Board Eligible or Board Certified:_____
If Certified, Date of Certification or Recertification:_____
If Eligible, Expected Date of Examination:_____

Subspecialty Certificate in Surgery of the Hand (Y/N):____
If Yes, Date of Certification or Recertification:_____
If No, Expected Date of Examination: _____

CURRENT PRACTICE

Illinois State Medical License #:_____
Months Currently Practicing at Same Location:_____
Total Surgical Cases in Past 12 Months:_____
Total Hand Surgical Cases in Past 12 Months:_____

CURRENT HOSPITAL AND SURGERY CENTER AFFILIATIONS

- Primary Hospital

Name:_____
City and State:_____

- Other Hospital/Surgery Center

Name:_____
City and State:_____

- Other Hospital/Surgery Center

Name:_____
City and State:_____

- Other Hospital/Surgery Center

Name:_____

City and State:_____

- Other Hospital/Surgery Center

Name:_____
City and State:_____

- Other Hospital/Surgery Center

Name:_____
City and State:_____
_____

If Additional Space is Needed, Please Duplicate this Sheet

RECOMMENDATION

Name of an Active Member, Per CSSH By-Laws, Who Will Support Your Application:
Active Member's Name:_____
How Long Have You Known this Active Member?:_____
In What Capacity is He/She Familiar with You as a Hand Surgeon?:
_____
_____
_____
Please ask this individual to send a short letter of support to the address below

Optional Additional Active Member Name:_____
How Long Have You Known this Active Member?:_____
In What Capacity is He/She Familiar with You as a Hand Surgeon?:
_____
_____
_____

ADDITIONAL INFORMATION

1) Have you ever been convicted of a felony? Yes No
2) Have you ever had your license to practice medicine restricted and/or revoked either through voluntary or involuntary action or surrender? Yes No
3) Have you ever had hospital membership and/or privileges restricted, revoked and/or denied? Yes No
4) Have you ever had any membership in any society and/or association revoked, restricted and/or denied? Yes No
5) Have you ever been censured by a state, medical society, and/or hospital? Yes No

****If you answered yes to any of these questions, please provided additional information explaining the reason, outcome and/or status of the situation****

AUTHORIZATION

In furtherance of my application for membership, I request and authorize the CSSH to evaluate and validate my credentials and information submitted for this application. I request and authorize any entity that may have information which they deem relevant to my fitness for membership, to provide such information to the CSSH.

I hereby waive any claim for damages, or otherwise, that I may have against any hospital, medical staff, medical organization, or individual who supplies information with the respect to my application, the CSSH, its officers, members, employees and agents of any act of omission or commission that they, or any of them, may take in good faith in connection with this application. I understand that the decision as to whether I qualify for membership vests solely and exclusively in the CSSH and that its decision is final.

I certify that my answers submitted for this application are complete, true and correct to the best of my knowledge.

Signature:_____ Date:_____/_____/_____

Printed Name:_____

Please e-mail a copy of your completed application to:
cssh.officers@gmail.com

Or mail to:
Chicago Society for Surgery of the Hand
c/o Matthew Bernstein, Barrington Orthopedic Specialists
929 W. Higgins Road
Schaumburg, IL 60195