



MEMBERSHIP APPLICATION

Please Return Application and Fees of \$150.00 to:
Georgia Vascular Society, Inc.
c/o Burkhardt Planning & Consulting
2520 Vestal Parkway East #238, Vestal, NY 13850
(678) 242-5273 / Fax: (678) 805-4631
liz@georgiavascularsociety.org

To the Executive Council of the Georgia Vascular Society, I hereby make application for membership in the Georgia Vascular Society.

Date of Application: _____

PERSONAL INFORMATION (please print or type)

 Last Name First Middle

AMA Medical Education #: _____ GA Medical License #: _____

Sex: Male Female Date of Birth: ____/____/____ Spouse Name: _____

Citizenship: _____

MAILING INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at OFFICE HOME

 Group Practice Name Cell Phone

 Office Address Home Address

 Office City/State/Zip Home City/State/Zip

 Office Phone Office Fax Home Phone Home Fax

 Office Email Address Home Email Address

EDUCATION

Pre-Medical School: _____ Date: _____

Degree: _____

Medical School: _____ Date: _____ MD DO

Residency: _____ Date: _____

Fellowship: _____ Date: _____

Other Educational or Research Experiences: (May Be Listed Separately) _____

PUBLICATIONS

Publications: (May Be Listed Separately) _____



Georgia Vascular
SOCIETY

CASES FOR THE PAST 24-MONTH PERIOD	NO. OF CASES
AAA Repair by Open or Stent Graph	
Carotid Endarterectomy or Stent	
Extremity Revascularization either Open or Endovascular	
Major Vessel Repair for Trauma	
Angiography of Venous or Arterial System or Dialysis Access with or without Intervention	
Major Amputation above the Ankle or Wrist	
Dialysis Access Creation by Fistula, Shunt or Catheter	
<i>Other:</i>	
<i>Other:</i>	
<i>Other:</i>	