



# Membership Application

aslms.org

## APPLICANT INFORMATION

Salutation (Mr., Ms., Mrs., Dr., Prof.) \_\_\_\_\_ Degree (i.e. MD, PhD) \_\_\_\_\_ Title \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Membership Status  New  Returning Gender  Male  Female  Non-Binary  Prefer Not to Say

**TO COMPLY WITH FEDERAL REGULATIONS, ALL NON-UNITED STATES CITIZENS MUST PROVIDE THE INFORMATION INDICATED WITH A »**

» Date of Birth (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_ » Citizenship \_\_\_\_\_ » Passport Number \_\_\_\_\_

» Resident Address \_\_\_\_\_ » City \_\_\_\_\_ » State/Province \_\_\_\_\_

» Zip/Postal Code \_\_\_\_\_ » Country \_\_\_\_\_

Business/Practice Name \_\_\_\_\_ Business Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Phone  Business  Home \_\_\_\_\_ Cell \_\_\_\_\_ Personal Email (Required) \_\_\_\_\_

Business Email \_\_\_\_\_ Administrative Email \_\_\_\_\_ Website URL \_\_\_\_\_

If you consent to receiving text messages from ASLMS including updates and reminders, please select the checkbox below and add your cell number above.

By selecting this checkbox, I consent to receive text messages from ASLMS (you may change this preference at any time by contacting information@aslms.org)

## CURRICULUM VITAE / RESUME

**EDUCATION** – *Begin with a baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.*

Institution and Location Degree (if applicable) Graduation Date (MM/DD/YYYY) Field of Study (specialty)

Institution and Location	Degree (if applicable)	Graduation Date (MM/DD/YYYY)	Field of Study (specialty)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**BOARD CERTIFICATION – PHYSICIANS ONLY** – *If applicable.*

To be designated as being “Board Certified,” an individual must have received certification from one of the following:

1) an American Board of Medical Specialties (ABMS) approved board, 2) an organization recognized by the American Podiatric Medical Association (APMA) as qualified to certify physicians as doctors of podiatric medicine, 3) an American Osteopathic Association (AOA) approved board, 4) the Royal College of Physicians and Surgeons of Canada (RCPSC), 5) the College of Family Physicians of Canada (CFPC), or 6) the American Dental Association (ADA) approved board as qualified to certify Doctors of Dentistry.

Board	Specialty	Year Certified
_____	_____	_____
_____	_____	_____

**NON-PHYSICIAN SPECIALTY AND CERTIFICATION** – *If applicable.*

Specialty/Certification	Year Certified
_____	_____
_____	_____

## LASER EXPERIENCE

Please describe your experience \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## SOCIAL MEDIA

Personal Facebook Handle \_\_\_\_\_ Personal Instagram Handle \_\_\_\_\_

Personal LinkedIn URL \_\_\_\_\_ Personal X Handle \_\_\_\_\_

Professional Facebook Handle \_\_\_\_\_ Professional Instagram Handle \_\_\_\_\_

Professional LinkedIn URL \_\_\_\_\_ Professional X Handle \_\_\_\_\_

## LASER PROCEDURES

- » List laser and related technology procedure(s) (i.e., Hair Removal, Tattoo Removal, Skin Rejuvenation, Port Wine Stains, Lasik, Nasal Polyps, etc.)
- » Do not list equipment manufacturers or equipment names.
- » ASLMS has the right to refuse any and all special laser and related technology procedures without a requirement to justify this refusal.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_  
5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_  
9. \_\_\_\_\_ 10. \_\_\_\_\_ 11. \_\_\_\_\_ 12. \_\_\_\_\_  
13. \_\_\_\_\_ 14. \_\_\_\_\_ 15. \_\_\_\_\_ 16. \_\_\_\_\_  
17. \_\_\_\_\_ 18. \_\_\_\_\_ 19. \_\_\_\_\_ 20. \_\_\_\_\_

## CRIMINAL / DISCIPLINARY HISTORY – *Application is not considered complete without the following information:*

Have you ever been the subject of a criminal prosecution or of a grievance, complaint, or proceeding that could have resulted in revocation, suspension, or restriction of any professional license issued to you by a governmental authority?

Yes  No If yes, please attach a statement describing the dates, nature, and outcome of the criminal prosecution or of the grievance, complaint, or proceeding and any relevant information.

Has an institution or professional organization ever disciplined you, or are you currently the subject of a complaint or disciplinary proceeding within an institution or professional organization?

Yes  No If yes, please attach a statement describing the dates, nature, and outcome of the complaint or proceedings and any relevant information.

## ROLE WITHIN YOUR PRACTICE OR INSTITUTION / AMA MEMBER INFORMATION / AREA OF INTEREST

Primary Role \_\_\_\_\_ Secondary Role \_\_\_\_\_

Are you an AMA Member  Yes  No If Yes provide AMA Member Number \_\_\_\_\_

Primary Area of Interest (i.e. Aesthetics, Dermatology, Engineering, etc.) \_\_\_\_\_

## WHAT DO YOU HOPE TO GAIN FROM YOUR MEMBERSHIP?

Select any that apply

Networking  Education  Member savings on conference & other in-person & online education  Journal / Learn current research

Committee & leadership opportunities  Access to the leading authors and speakers  Prestige of membership in ASLMS

Other \_\_\_\_\_

## HOW DID YOU HEAR ABOUT ASLMS?

ASLMS Member – Name \_\_\_\_\_  Email

Referral from Industry – Company Name \_\_\_\_\_  Direct Mailing

Publication Ad/New Article – Publication Name \_\_\_\_\_  ASLMS Website

Specialty Society Meeting – Name of Society \_\_\_\_\_  Social Media

Other \_\_\_\_\_

## DISCRIMINATION POLICY / SIGNATURE REQUIRED

The Society does not discriminate on the basis of race, color, religion, creed, gender, national origin, ancestry, age, disability, or sexual orientation in any aspect of its operations, including, but not limited to, the provision of services, membership on the Society's governing board or committees, and attendance at or participation in the Society's programs, grant selection, meetings, and events.

I recognize that membership in the American Society for Laser Medicine and Surgery, Inc. (ASLMS) is a privilege, not a right, and is subject to and governed by the Society's Articles of Incorporation, Bylaws, Administrative Regulations, Code of Ethics, and other rules that the Society may adopt. If accepted as a member of the Society, I agree to abide by its rules. I recognize the importance of the Society's ability to investigate the qualifications of the applicants for membership and maintain standards of conduct for its members. The Society must be able to perform its investigatory and disciplinary functions without fear of litigation by rejected applicants or disciplined members. I consent to any investigation of the facts disclosed in this application, to any disciplinary investigation during my membership in the Society, and to any statements made in the application or disciplinary process, by whomever made and whether defamatory or not. In return for consideration of my application, I consent to the Society inviting and receiving information and comment about me from any member or other person, and I agree that any information and comment furnished to the Society in response to such invitation shall be conclusively deemed confidential and privileged, and I waive any claim or cause of action and release the Society, its members, directors, officers, or agents and any person furnishing information or comment in response to an invitation from the Society for any damage or liability by reason of any action any of them take in connection with this application.

If elected to membership in the Society, I further waive any claim or cause of action against the Society, its members, directors, officers, Ethics and Conflict of Interest Committee members, agents, or any person reporting, furnishing information, or commenting about me in connection with any disciplinary action of the Society.

I understand that by providing my mailing address, email address, telephone number, and fax number, I consent to receive communications sent by or on behalf of the ASLMS via regular mail, email, telephone, or fax.

Sign Full Name \_\_\_\_\_ Date \_\_\_\_\_

**ANNUAL MEMBERSHIP FEES**

**STANDARD ANNUAL MEMBERSHIP**

**Associate** – Any scientist, engineer, physician, other health care professional, or any individual who is qualified and duly licensed to engage in independent clinical practice and is qualified and recognized in his or her respective field. Any individual who is recognized as being significantly involved with the laser industry shall also be eligible to become a Member.

Select One  \$375 (US) Physician/Industry  \$180 (US) Scientist  \$130 (US) Nursing/Allied Health

**EARLY CAREER ANNUAL MEMBERSHIPS**

**2nd Year** – If you have completed your training in the last two years. Must include training completion date: \_\_\_\_\_

Select One  \$248 (US) Physician/Industry  \$119 (US) Scientist  \$86 (US) Nursing/Allied Health

**1st Year** – If you have completed your training in the last year. Must include training completion date: \_\_\_\_\_

Select One  \$125 (US) Physician/Industry  \$60 (US) Scientist  \$43 (US) Nursing/Allied Health

**Graduate Student** – Any scientist, engineer, physician, or health care professional who has earned a bachelor's degree, and is pursuing further education in science, engineering, biology, medicine, surgery or other related discipline may be considered for Graduate Student status. Please check the category that applies.

Select One  Medical Student  Graduate Student  Resident  Intern  Fellow-in-Training

**Undergraduate Student** – Any student who is seeking an undergraduate degree at an accredited educational institution may be admitted as an Undergraduate Student member. This class is non-voting.

**Students - Application is not considered complete without the following information.**

Training Currently Engaged In \_\_\_\_\_

Name of Institution \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_

Director/Trainer Name and Title \_\_\_\_\_ Date Training to be Completed \_\_\_\_\_

**REQUIRED:** A letter from your educational program specifying your completion date and degree/training pursued.

**NO PAYMENT REQUIRED FOR STUDENT MEMBERSHIP - PLEASE CONTINUE TO SUBMIT APPLICATION**

**PAYMENT INFORMATION – IN US DOLLARS**

**ANNUAL MEMBERSHIP FEES (Fees are non-refundable unless application is not approved for membership)**

Membership Fee Selected Above ..... \$ \_\_\_\_\_

ASLMS Research Fund Contribution..... \$ \_\_\_\_\_

Total (USD)..... \$ \_\_\_\_\_

**PAYMENT METHOD**

Payment by Check  Enclosed Payment must be made in US dollars only and drawn on a US bank. Make check payable to ASLMS. Individuals from countries sanctioned by the U.S. Treasury Department's Office of Foreign Assets Control must use third-country financial institutions as intermediaries for all payments to the ASLMS.

Payment by Credit Card  Visa  MasterCard  American Express

Credit Card # \_\_\_\_\_ Expiration Date (MM/YY) \_\_\_\_\_ / \_\_\_\_\_

Name on Card (print) \_\_\_\_\_

Signature \_\_\_\_\_

**SUBMIT APPLICATION**

Mail your application to 100 N. 72nd Ave., Wausau, WI 54401 -OR-

» Email your application to information@aslms.org

» You may provide your credit card information via phone: (715) 845-9283 or toll Free (877) 258-6028