E · A · E · S

European Association for Endoscopic Surgery
and other Interventional Techniques

MEMBERSHIP APPLICATION FORM

Prof/Dr/Mr/Ms

Applicant's Name: _____ _____
Last Name First Name

_____ _____
Date and Place of Birth Country

☐ Physician ☐ Resident in Training

Specialty: _____

For mailing address please tick appropriate box:

☐ Business address

Hospital: _____

Department: _____

Address: _____

City: _____ Zip Code: _____

Country: _____ Mobile: _____

Phone: _____ Fax: _____

E-mail: _____

☐ Private Address

Address: _____

City: _____ Zip Code: _____

Country: _____ Mobile: _____

Phone: _____ Fax: _____

E-mail: _____

1. **Education:** Institution Degree & Date Awarded

College/University _____

Medical School _____

Postgraduate Training _____

Type Institution

Internship _____

Residency _____

Fellowship _____

Other _____

2a. (For Physicians only)

Board Certification.

Specialty Board _____ Certificate # _____ Date _____

Specialty Board _____ Certificate # _____ Date _____

2b. (For Residents in Training only)

When do you expect to complete your surgical training? _____ (Date)

Medical License (a copy must be attached)

Country/Place _____ Date _____

3a. **Membership of national surgical or other Societies** Yes _____ No _____

3b. **Membership in Medical and Scientific Societies**

Name Date of Election

_____

_____

_____

_____

4. **Did you have formal endoscopic training?** Yes _____ No _____

Program: Director: Inclusive Dates

_____

_____

Training outside formal program: _____

_____

5. (For physicians only)

Do you teach endoscopic surgery? Yes: _____ No: _____

6. **Current Endoscopic Experience:**

Procedures	Included in program		Teaching (for physicians only)	
Upper G.I. Endoscopy	☐ Yes	☐ No	☐ Yes	☐ No
ERCP	☐ Yes	☐ No	☐ Yes	☐ No
Colonoscopy	☐ Yes	☐ No	☐ Yes	☐ No
Laparoscopy/ (Diagnostic or Emergency)	☐ Yes	☐ No	☐ Yes	☐ No
Laparoscopic Surgery	☐ Yes	☐ No	☐ Yes	☐ No
Choledochoscopy	☐ Yes	☐ No	☐ Yes	☐ No
Endoscopic Laser Procedures	☐ Yes	☐ No	☐ Yes	☐ No
Other _____			☐ Yes	☐ No
_____			☐ Yes	☐ No
_____			☐ Yes	☐ No

7. **Academic Appointments** (begin with current)

Institution	Title	Clinical?	Full Time?	Inclusive Dates

8. **Hospital Appointments** (begin with current)

Institution	Inclusive Dates

I authorize the European Association for Endoscopic Surgery to obtain information from any source regarding this application and my qualifications for membership, which information will be kept confidential by the Society.

_____

Applicant's signature

INSTRUCTIONS FOR SUBMISSION OF E A E S

MEMBERSHIP APPLICATION

Documents required:

Please send a copy of the following documents to the Executive Office.

Physicians:

- **A completed and signed application form**

Residents in Training:

- **A completed and signed application form**
- **Letter of Recommendation from your current Chief of Department or Instructor**
- **Copy of your Medical School Diploma**

Please sent these documents either by post/fax or email to:

EAES Office
Attention Membership Administrator
P O Box 335
5500 AH Veldhoven
The Netherlands
Tel +31 40 252 5288
Fax +31 40 252 3102
Email: membership@eaes.eu

Your EAES membership is automatically renewed yearly on 1 October. Notice of termination of membership must be received by the EAES office on or before this date. Failure to give timely notice of termination of membership will result in your membership being automatically renewed for an additional year with all resulting consequences, such as your indebtedness for dues (and other applicable costs and fees, if any).

If you have any questions concerning your application, please contact the Membership Administrator at the EAES Office,
Tel: +31 40 252 52 88
Fax: +31 40 252 31 02
E-Mail: membership@eaes.eu
www.eaes.eu