THE WESTERN NEUROSURGICAL SOCIETY

APPLICATION FOR MEMBERSHIP

NAME ____

OFFICE ADDRESS____

____

OFFICE PHONE________________________________ FAX____________________________

HOME ADDRESS____

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HOME PHONE________________________________ FAX______________________________

E-MAIL____

PLACE AND DATE OF BIRTH____

SPOUSE'S NAME ______________________________ email ____________________________

TYPE OF MEMBERSHIP____
(Active, Corresponding, Honorary, Associate)

BOARD CERTIFICATION (board and date) ____________________________________

CURRICULUM VITAE: Send as Word document to Dr. Lee at marcolee@stanford.edu

PICTURE: Send head and shoulders picture as jpeg file to Dr. Lee

Proposer: ____

Sponsor #1 ____

Sponsor #2 ____
(One of the above should be from your locale—membership list by location on Website-westnsurg.org)

SIGNATURE____

Date ____________________________________

Please save completed form and attach to email to Marco Lee, MD, PhD at marcolee@stanford.edu

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