Academy of Minimally Invasive Foot & Ankle Surgery

MEMBERSHIP APPLICATION

Complete form and return to: Director@amifasintl.org

If paying by check, mail form and check to:
AMIFAS c/o Ann Dosen
PO Box 1083
Chapin, SC 29036

FIRST NAME _____

LAST NAME _____

DEGREE (DPM, MD, ETC.) _____

ADDRESS ☐ OFFICE ☐ HOME _____

ADDRESS LINE 2 _____

CITY _____

STATE, ZIP, COUNTRY _____

EMAIL ADDRESS _____

PRACTICE SETTING ☐ HOSPITAL ☐ MULTI-SPECIALTY GROUP ☐ PRIVATE PRACTICE ☐ OTHER

OFFICE PHONE _____

MOBILE PHONE _____

PRE-MED COLLEGE/UNIVERSITY _____

MEDICAL SCHOOL NAME _____

MEDICAL – DEGREE EARNED _____

MEDICAL SCHOOL – GRAD YEAR _____

POST-GRAD INTERNSHIPS, RESIDENCY, FELLOWSHIP NAME _____

MIS SURGICAL EXPERIENCE ☐ LESS THAN 5 YEARS ☐ 5-10 YEARS ☐ MORE THAN 10 YEARS

STATE LICENSE & NUMBER (1) _____

STATE LICENSE & NUMBER (2) _____

ARE YOU A CURRENT AMIFAS FELLOW? ☐ YES ☐ NO ☐ UNSURE

PAYMENT METHOD ☐ CHECK ENCLOSED ☐ CREDIT CARD

CARD NUMBER _____

EXP DATE _____

CVV CODE _____

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TERM OPTIONS	**SELECT**
ONE-YEAR: ☐ USA **$495** ☐ INTERNATIONAL **$250**	☐
TWO-YEAR **$749** (USA ONLY) SAVE $241!	☐
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☐ STUDENT ☐ RESIDENT *(NO CHARGE; REQUIRES VERIFICATION)*	☐

By signing this form, I am authorizing AMIFAS to charge the card for the amount indicated above.

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Signature

Date: _____

Questions? Call Ann at (800) 479-4936 or email Director@amifasintl.org