

CONGRESS OF NEUROLOGICAL SURGEONS



Education and Innovation

ACTIVE INTERNATIONAL MEMBERSHIP APPLICATION

The Congress of Neurological Surgeons (CNS) exists to enhance health and improve lives worldwide through the advancement of education and scientific exchange.

BENEFITS:

- Complimentary subscription to *NEUROSURGERY*[®], the official CNS journal.
- Complimentary *Operative Neurosurgery*, a supplement to *NEUROSURGERY*[®]
- Complimentary *Congress Quarterly*, the official CNS news magazine.
- Complimentary *Clinical Neurosurgery*.
- Discounts on **sans** Lifelong Learning - an online self-assessment tool, as well as SANS: Spine, SANS: Pediatrics, SANS *Competencies* and SANS *Neurotrauma*.
- Complimentary access to CNS University, featuring more than 40 online courses and webinars.
- Reduced registration fee for CNS Annual Meeting.
- Opportunity to participate in the organization through volunteering on various CNS committees (such as the International Committee).
- Reduced prices on other CNS publications and courses.
- Ability to manage your member account and meeting participation via your online CNS Account.

REQUIREMENTS:

- 1.) Please note that to be an Active International Member of the *Congress of Neurological Surgeons*, you must reside and practice neurosurgery outside North America (the United States, its territories, Canada and Mexico)
- 2.) Be a member of your local or regional Neurosurgical society.
- 3.) Provide the names of two CNS member references or a certificate or letter of verification from your local or regional neurosurgical society.
- 4.) Please type or print clearly in English and complete all items on the application.

DUES:

The annual fee for CNS Active International Membership is \$575 (U.S. currency) plus a one-time processing fee of \$25 (U.S. currency). After your application has been reviewed by the International and Membership Committees and approved by the CNS Executive Committee, a dues invoice will be sent to you. Please do not remit any money at this time.

Checklist for the application:

- Completed and signed application form Curriculum Vitae enclosed
- Two CNS member references or certificate or letter of verification from your local or regional neurosurgical society

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APPLICATION FOR ACTIVE INTERNATIONAL MEMBERSHIP

I. BIOGRAPHICAL

Name: Last _____ First _____ Middle _____

Place of birth: _____ Date of Birth (MM/DD/YYYY): _____

Citizenship/Nationality: _____

Organization: _____

Street Address: _____

Suite/Department: _____

City, State/Province, Postal Code, Country: _____

Phone: _____ Fax: _____ **EMAIL:** _____

Home Address: _____

City, State/Province, Postal Code, Country: _____

No, do not send me CNS product and service updates and information via email.

No, do not display my email address in the CNS Online Member Directory.

Please send correspondence to this address: work or home

II. TRAINING

Medical School: _____ Date of Graduation: _____

Primary Neurosurgical Training: _____ Dates: _____

Program Director or Chief of Service: _____

Degree(s) earned: _____

Other Training: _____ Dates: _____

Program Director or Chief of Service: _____ Your position _____

III. REFERENCES*

Please list two references that are MEMBERS of the CONGRESS OF NEUROLOGICAL SURGEONS.

Do NOT include your Program Director (listed under Section II as a reference.

Reference 1: Name: _____

Address: _____

City, State/Province, Postal Code, Country: _____

Email: _____ Fax: _____

Reference 2: Name: _____

Address: _____

City, State/Province, Postal Code, Country: _____

Email: _____ Fax: _____

* If you do not have two references, attach a copy of your Membership Certificate or a Letter of Verification from your local or regional neurological society.

IV. MEMBERSHIP, CERTIFICATION, AND PRACTICE

Do you limit your practice to Neurosurgery? Yes No

Are you certified by a Neurosurgery Examining Organization? Yes No

Name and Address of Organization _____

Local or Regional Neurosurgery Society Membership (Required):

Name of Society _____ Date Active _____

Other Neurosurgical Society Memberships: _____

V. ADDITIONAL REFERENCES Please Attach a Curriculum Vitae (Required)

LIST OF PUBLICATIONS:

ACADEMIC POSITIONS CURRENTLY HELD:

CURRENT HOSPITAL APPOINTMENTS:

MEMBERSHIP IN NEUROSURGICAL SOCIETIES

SIGNATURE _____

DATE _____

Please return the application to: **Congress of Neurological Surgeons
10 N. Martingale Road, Suite 190
Schaumburg, IL 61093 USA**

**Phone: 001 847 240 2500
Fax: 001 847 240 0804
Email: info@1cns.org**

Please complete the Authorization and Release form on the back



CONGRESS OF NEUROLOGICAL SURGEONS AUTHORIZATION AND RELEASE

1. Authorization: I hereby authorize the Congress of Neurological Surgeons (hereinafter referred to as the “Congress”) and its board of directors, membership committee, professional conduct committee, or any of their employees and agents (each a Congress representative) to: consult or make inquiry of any physician, hospital, health system, medical school, medical training program, medical association, specialty board, licensing authority, professional liability insurance carrier, broker or agent, personal reference, individuals and/or organizations concerned with provider performance and the quality and efficiency of patient care, and individual or organization who has been associated with me and/or who has information bearing on my ability, training, education, professional ethics, character, emotional stability, professional liability experience, and other qualifications pertinent to membership in the Congress;

AND inspect and obtain copies of all records and documents that may be material to evaluating my professional qualifications, competence, ethical standards and practice patterns or otherwise related to qualifications pertinent to membership in the Congress.

2. Release: I hereby authorize and consent to the release of information by: each individual and organization who provides information to the Congress or its representative in good faith concerning my ability, training education, professional ethics, character, emotional stability, professional liability experience, and other qualifications pertinent to membership in the Congress, including otherwise privileged or confidential information;

AND the Congress and representatives to any physician, hospital, medical school, medical training program, medical association, specialty board, licensing authority, professional liability insurance carrier, broker or agent, personal references, and individuals or organizations concerned with provider performance and the quality and efficiency of patient care, any information relevant to such matters that the Congress or its representatives may have concerning me regarding my ability, training, education, professional ethics, experience and other qualifications pertinent to membership in the Congress.

3. Indemnification: I hereby discharge from any liability and agree to indemnify, defend and hold harmless from any liability (including reasonable attorney’s fees and expenses) all:

Individuals and organizations who provide information to Congress in good faith, including otherwise privileged or confidential information; and Congress and Congress representatives For their acts performed in good faith in connection with obtaining or providing information about me and evaluating my credentials and qualifications.

I hereby agree that no information obtained by the Congress or its representatives pursuant to any pre-application, application or re-application process shall be subject to discovery, subpoena or other means of legal compulsion for release by me or my agents.

4. Truth and accuracy of information: I hereby certify that all information submitted by me to the Congress (whether in an application, CV or otherwise) is true to my best knowledge and belief. I understand and agree

- (i) to update the Congress so that all information contained in my application for membership remains true at all times; and
- (ii) that providing false or misleading information shall be grounds for denial or termination of membership in the Congress without right to further process.

5. Membership Dues and Assessments: I hereby acknowledge financial responsibility to timely pay all membership dues and other financial assessments imposed on my by the Congress.

6. Membership Pledge: I pledge that at all times while I am a member of the Congress to uphold the ideals and goals of the Congress and to continuously strive to provide quality and efficient care to my patients in a cost effective manner.

A photocopy of this form shall suffice as an original for the purpose of authorizing release of information.

Signature

Date