Congress of Neurological Surgeons

INTERNATIONAL VISTA RESIDENT 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*, *Operative Neurosurgery*, *Congress Quarterly*, and *Clinical Neurosurgery*
- Complimentary access to The Surgeon's Armamentarium, an advanced digital search platform that provides customized search results from the archives of the *NEUROSURGERY*® Publications
- Discounts on our online SANS Lifelong Learning self-assessment tools, including: SANS: Indications, SANS: General, SANS: Specialty Module Bundle, SANS: Written Board Modules, and more
- Access to our Online Education Catalog with more than 100 online courses and discounted webinars for members, in addition to more than 100 annual meeting recorded sessions
- The free CNS Guidelines App, with immediate, point-of-care access to guideline recommendations and topic overviews, along with links to full text, for all CNS-produced evidence-based clinical practice guidelines
- Access to the Neurosurgery Survival Guide (NSG) App, a trusted quick reference guide that encompasses the massive breadth of knowledge and information needed when caring for neurosurgery patients
- Complimentary access to Nexus, the CNS' comprehensive, case-based repository of neurosurgical operative techniques and approaches
- Exclusive member rates at the CNS Annual Meeting—and all live courses
- Volunteer leadership opportunities through an extensive array of committees
- Online management of CME credit, member account, and meeting participation

DUES:

The annual fee for CNS International Vista Resident Membership is $50 USD. After your application has been reviewed and approved by the CNS Membership Committee, a dues invoice will be sent to you. Please do not remit any money at this time.

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REQUIREMENTS:

Please note that to be eligible as a CNS International Vista Resident Member, you must be enrolled in an International neurosurgical training program outside North America (the United States, its territories, Canada and Mexico), or in a fellowship immediately following completion of an International neurosurgical training program. *Also, the Applicant must submit a CV and signed letter from the program or fellowship director stating that the applicant is a resident or fellow in good standing. The letter must be on university or hospital letterhead and include the student's enrollment date and expected date of graduation.* Membership will renew automatically and terminate immediately upon completion from residency/fellowship training. Upon graduation, you are encouraged to reapply for CNS Active International or International Vista Membership. Please send completed applications to:

Congress of Neurological Surgeons
10 N. Martingale Road, Suite 190
Schaumburg, IL 60173 USA

E-Mail: membership@cns.org
Phone: 001 847 240 2500
Fax: 001 847 240 0804

Please note: International Vista Resident members will receive all CNS publications via Internet Access with your own unique user name and password which will be provided by the CNS. After your application has been reviewed and approved by the CNS Membership Committee, a dues invoice will be sent to you. Upon completion of your neurosurgical training, your International Vista Resident membership will cease, and you will be invited to apply for International membership.

I. BIOGRAPHICAL

Name: Last_____ First_____ Middle _____

Citizenship/Nationality:_____ Date of Birth (MM/DD/YYYY):_____

E-MAIL: _____

Organization_____

Street Address _____

Suite/Department_____

City, State/Province, Postal Code, Country_____

Phone:_____ FAX: _____

☐ No, do not send me CNS product and service updates and information via email.
☐ No, do not display my address on the CNS Online Member Directory.

II. TRAINING

Medical School:_____

Date of Graduation:_____ Degree:_____

Neurosurgical Training Program: _____

Anticipated Date of Completion: _____

Congress of Neurological Surgeons

Program Director Information:

Name:_____

Address: _____

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

Office Phone:_____Fax:_____

Email: _____

III. ATTACH A SIGNED VERIFICATION LETTER FROM YOUR PROGRAM DIRECTOR, AND A CURRICULUM VITAE (CV).

By signing this form, you agree that the CNS can retain this information for the purposes of communication and service support set out in our Privacy Policy, which can be viewed at https://www.cns.org/privacy-policy. If you do not want your information retained, please email privacy@cns.org.

Applicant Signature:

_____Date: _____

Please return the application and letter of residency enrollment verification to:

Congress of Neurological Surgeons 10 N. Martingale Road, Suite 190 Schaumburg, IL 60173 USA

Phone: 001 847 240 2500
Fax: 001 847 240 0804
E-mail: membership@cns.org

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.

By signing this form, you agree that the CNS can retain this information for the purposes of communication and service support set out in our Privacy Policy, which can be viewed at https://www.cns.org/privacy-policy. If you do not want your information retained, please email privacy@cns.org.

Signature_____ Date _____