APPLICATION FOR ASSOCIATE MEMBERSHIP

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

**REQUIREMENTS:**

“Applicants for Associate Membership in the Congress of Neurological Surgeons (CNS) are physicians and/or scientists who”:

- Are not ABNS eligible neurological surgeons;
- Have shown distinction in some neurosurgically related discipline, and;
- Have been recommended for membership in writing by two Active Members of the CNS.

- Associate Members shall pay dues and may serve on committees but may not vote or hold office.

**DUES:**

The annual fee for CNS Associate Membership is $360 (U.S. currency) plus a one-time processing fee of $25 (U.S. currency). After your application has been reviewed and approved by the Membership Committee by the CNS Executive Committee, a dues invoice will be sent to you. Please do not remit any money at this time.
APPLICATION FOR ASSOCIATE MEMBERSHIP

I. BIOGRAPHICAL:
Name: ____________________________________________________________
Date of birth (MM/DD/YYYY): __________________________ Place of birth: __________________________
Citizenship: ______________________________________________________
Residence Address: ________________________________________________
City, State, Zip: __________________________________________________
Telephone No.: __________________________ Email address: __________________________

Organization: _____________________________________________________
Address: __________________________________________________________
City, State, Zip: __________________________________________________
Telephone No.: __________________________ Fax: __________________________

☐ 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: __________________________ Degree: __________________________
Primary Training (please list dates and position(s) held)
____________________________________________________________________
____________________________________________________________________
Other training (please list dates and position(s) held)
____________________________________________________________________
____________________________________________________________________

III. REFERENCES
Please list two (2) references who are MEMBERS of the CONGRESS OF NEUROLOGICAL SURGEONS.

Reference 1: Name: _____________________________________________________
Email: ______________________________________________________________
Phone: ______________________________________________________________

Reference 2: Name: _____________________________________________________
Email: ______________________________________________________________
Phone: ______________________________________________________________
IV. MEMBERSHIP, CERTIFICATION AND PRACTICE

Does your formal training meet the requirements for eligibility for examination by the AMERICAN MEDICAL BOARDS? □ Yes □ No

Are you board certified? □ Yes □ No

If YES, what year did certification take effect? __________

Are you certified by another examining body? □ Yes □ No

If YES, what year did certification take effect? __________

List Board Examining body: __________________________________________

Local, Regional or State Medical Society Membership.

Name: __________________________________________ Date: ______

Are you a member of the AMERICAN MEDICAL ASSOCIATION? □ Yes □ No

Are you licensed to practice medicine? □ Yes □ No

State: _______________ Issued ___________ Valid through __________

State: _______________ Issued ___________ Valid through __________

PRACTICE TYPE (Circle one)

Academic Government
Private-Group Academic/Private
Private-Solo Military
Private-Solo Other

Retired Other

V. ADDITIONAL REFERENCES

LIST OF PUBLICATIONS:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

ACADEMIC POSITIONS CURRENTLY HELD:

________________________________________________________________________

________________________________________________________________________

CURRENT HOSPITAL APPOINTMENTS:

________________________________________________________________________

________________________________________________________________________

MEMBERSHIP IN MEDICAL SOCIETIES

________________________________________________________________________
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________________________
ASSOCIATE MEMBERSHIP APPLICATION CHECKLIST

Please make sure you have completed the application and submitted the following items:

- Completed and signed application
- Signed authorization of release form
- Provide information for your two sponsoring neurosurgeon references. 
  NOTE: References must be CNS members.
- Photograph enclosed  *Optional
- Curriculum Vitae enclosed  *Optional

You can speed your application by encouraging your references to respond promptly to our request and by joining your local medical society or attaining active hospital privileges.

Please return the application to:

Congress of Neurological Surgeons  Phone:  847 240 2500
ATTN: Member Services Department  Fax:  847 240 0804
10 N. Martingale Road, Suite 190  Toll Free: 877 517 1CNS
Schaumburg, IL 60173 USA  Email:  membership@cns.org