Congress of Neurological Surgeons

The global leader in neurosurgical education

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*.
- 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 Online Learning, featuring more than 100 online courses and discounted webinars for members.
- Opportunity to participate in the organization through volunteering on various CNS committees.
- Reduced registration fee for CNS Annual Meeting.
- Reduced prices on other CNS publications and courses.
- Ability to manage your CME credit, member account and meeting participation via your online CNS Account.

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.

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

V. ADDITIONAL REFERENCES

LIST OF PUBLICATIONS:

_____

_____

ACADEMIC POSITIONS CURRENTLY HELD:

_____

_____

CURRENT HOSPITAL APPOINTMENTS:

_____

_____

MEMBERSHIP IN MEDICAL SOCIETIES

_____

_____

SIGNATURE_____ DATE_____

Please complete the Authorization and Release form on the back

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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

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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
ATTN: Member Services Department
10 N. Martingale Road, Suite 190
Schaumburg, IL 60173 USA

Phone: 847 240 2500
Fax: 847 240 0804
Toll Free: 877 517 1CNS
Email: membership@cns.org