California Association of Neurological Surgeons
5380 Elvas Avenue, Suite 215, Sacramento, CA 95819, tel 916 457-2267; fax 916 457-8202,
www.cans1.org

Application for Membership

Full Name_____

Address_____

City _____ State_____ Zip Code_____

Telephone (include area code)_____Fax_____E-mail_____

Date of Birth_____ Place of Birth_____Citizenship_____

Medical School_____

Degree_____ Year of graduation_____

Internship _____ Year_____

Residency/Fellowship Training (indicate years)

_____

_____

Program Director _____

Military Experience _____ Years_____

Current Academic
Appointment_____

_____

Current Location of Neurosurgical Practice

_____

Principal Hospital _____

Secondary Hospitals _____

Please account for years spent in neurosurgical practice at other than present location since completing
neurosurgical training _____

_____

Sub-Specialty (if applicable)_____

Name_____

California License Number_____ Year_____

American Board of Neurological Surgery status: Certified _____ Year_____

Date letter rec'd from American Board_____ Eligible for exam_____

Other _____

(Enclose copies of Certification or letter from American Board)

MEMBERSHIPS:	yes	no
Fellowship, American College of Surgeons	____	____
American Medical Association	____	____
American Association of Neurological Surgeons	____	____
Congress of Neurological Surgeons	____	____
California Medical Association	____	____

Other local or regional neurological society memberships:

_____

I hereby apply for membership in the California Association of Neurological Surgeons and agree to abide by the published Bylaws. (Please call the CANS office if you would like to receive a copy of the bylaws.)

Signature of applicant _____ Date_____

***This application for membership is endorsed by the following member of CANS*:**

Member signature (e-sig ok) _____Date_____

Printed last name_____

Your application must be returned with a $50 application fee. Annual dues of $350 will not be collected until the second year of membership (first year is $175.00 after formal membership approval at the January Annual Meeting). Please pay by check _____ or credit card.

(please print clearly) *VISA*_____ *MasterCard*_____ *AmEx*_____*Discover*____

16-digit Card Number _____ - _____ - _____ - _____

Name as it appears on card _____ *Expiration Date* _____
email address for receipt _____

Contributions to the California Association of Neurological Surgeons are not tax deductible as charitable contributions; however, they may be tax deductible as ordinary and necessary business expenses. **Please complete this form and return to CANS at fax 916 457-8202 . email to emily@cans1.org or mail to: CANS, 5380 Elvas Ave., Ste. 215, Sacramento, CA 95819. Contact 916 457-2267 or emily@cans1.org if you need additional information.**

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FOR CANS OFFICE USE:

Date application received _____ Date of Annual Meeting for approval _____

Check number _____ Date_____ or Credit card approved_____

Additional information requested _____