The Florida Society of Dermatology & Dermatologic Surgery

6134 Poplar Bluff Circle, Suite 101 • Peachtree Corners, Georgia 30092
Phone: 904-880-0023 • Fax: 305-422-3327

Date _____

Name _____ Degree(s) _____

Date of Birth _____ ☐ Male ☐ Female FL license # _____

Practice Name _____

Practice Admin _____

Practice Admin Email _____

Office Address _____

City _____ State _____ Zip _____

Office Phone _____ Office Fax _____

Email _____

Fax or Mail to:

FSDDS
6134 Poplar Bluff Circle, Suite 101
Peachtree Corners, Georgia 30092
Fax: 305-422-3327

Membership: *(For membership information, please visit www.fsdds.org)*

I am applying for ____Fellow ____Associate ____Special Member ____Provisional Resident

Are you certified by the ABD? ☐ YES ☐ NO The AOBD? ☐ YES ☐ NO

If NOT, have you completed an ACGME/AOA approved dermatology residency? ☐ YES ☐ NO

What year will you be eligible for ABD or AOBD certification? _____

Please complete the following:

_____
Undergraduate

_____
Graduate/Medical School

_____
Internship/Residency

_____
Fellowship Program

_____
Other Training

Present Medical School/Hospital Affiliations:

_____

_____

Have your hospital privileges ever been curtailed or revoked? ☐ YES ☐ NO

Number of years in your current location _____

Is your practice ☐ Medical ☐ Surgery ☐ Cosmetic ☐ Other

Membership Dues
(Payment is due with the application)

☐ Membership Dues $325

Optional Donation
☐ PAC $250
☐ National Skin Education Foundation ... $100

Method of Payment:
☐ Check ☐ VISA ☐ MC ☐ AMEX

Amount $ _____ Exp. Date _____

Account #_____

Name on Card _____

Signature _____

Security Code_____

Email for receipt_____

I affirm that information submitted is true and correct to the best of my knowledge.
I hereby authorize the FSDDS to obtain verification of any of the above listed information.

_____ _____
Signature of Applicant Date