International Pediatric Endosurgery Group

APPLICATION FOR ALLIED HEALTH PROFESSIONAL MEMBERSHIP FOR NURSES, GI ASSISTANTS AND MD'S NOT CERTIFIED BY THE AMERICAN BOARD OF SURGERY

First Name:_____ M.I._____ Last Name:_____

Professional Title:_____ Date of Birth:_____

Your Primary Health Speacialty:_____

Mailing Address:_____

_____

City:_____ State/Region:_____ Zip/Postal Code:_____

Country:_____ Phone Number:_____ Fax Number:_____

E-mail Address:_____

❑ I am a practicing Nurse, GI Assistant, or M.D. not certified by the American Board of Surgery.

EDUCATION: (Please List Institution, Degree, & Years Attended)

College/University:_____

Medical/Nursing School:_____

Internship:_____

Other applicable training:_____

Please describe your current position:_____

DOCUMENTS REQUIRED TO COMPLETE THIS APPLICATION:

❑ A signed, fully completed application form.

❑ Annual dues for Allied Health Professionals Membership are $125 USD. Please make checks payable to IPEG.

AUTHORIZATION:

I authorize the International Pediatric Endosurgery Group to obtain information from societies, hospital staffs, members, and any other source regarding this application and my qualifications for membership, which information will be kept confidential by the Group.

Applicant's Signature:_____ Date:_____

Executive Offices: 11300 West Olympic Blvd., Suite 600, Los Angeles, CA 90064, USA. **Phone:** (310) 437-0553 **Fax:** (310) 437-0585 **Email:** membership@ipeg.org

A Subscription to the "Journal of Laparoendoscopic & Advanced Surgical Techniques" is included with your membership fees. **Fees** must be paid in US dollars, and may be remitted by check, MasterCard, Visa or American Express. Arrangement can be made for bank transfer, contact office for details.