American College of Foot and Ankle Surgeons®
Proven leaders. Lifelong learners. Changing lives.

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FootHealthFacts.org

ID#: ___________
Office Use

2024 – 2025 POST-GRADUATE FELLOWSHIP MEMBERSHIP APPLICATION

October 1, 2024 – September 30, 2025

Requires enrollment in 12-month Fellowship Program

Fellowship Program Information

Name of Fellowship Program: ______________________________

Fellowship Director Name: ______________________________

Signature of your Fellowship Director (required): ______________________________

Fellowship Completion Date: ____________________

Applicant Name (PLEASE TYPE OR PRINT IN BLOCK LETTERS)

First: ____________________ Middle: ______________ Last: ____________________ Suffix: _______

Previous Last Name: ______________________________

Academic Degree Abbreviations: _DPM, ______________________________

Spouse Name: ______________________________

Home Address ______________________________

(Mail is sent to home address)

City: ____________________ ST/Province:__________ Zip/Post Code: ____________ Country: __________ (OTHER THAN USA)

Phone

Home: ____________________ Mobile: ____________________

Email

Primary: ______________________________

Secondary:______________________________

Podiatric School

☐ AZCPM (AZ) ☐ Barry (FL) ☐ SMUCPM (CA) ☐ DMU (IA) ☐ Kent State (OH)
☐ NYCPM (NY) ☐ Temple (PA) ☐ Scholl (IL) ☐ Western U (CA)

Graduation Year: ______________

Residency

☐ PM&S-36 ☐ PMSR ☐ PMSR/RRA ☐ Other: ____________________

Residency Completion Date: ____________________

Residency Program Name: ______________________________

Residency Director's Name ______________________________

Batch # ____________________ Approval # ______________ Amount $ ______________
Office Use

Applicant: ____

I am ABFAS Board Qualified* in

- ☐ Foot Surgery ____________________ (date)
- ☐ RRA Surgery ____________________ (date)
- ☐ Not ABFAS Board Qualified, but plan on taking exam ____________________ (date)
- ☐ Not ABFAS Board Qualified and do not plan on seeking status

*Applicants who are verified to be Board Qualified with ABFAS will be provided with the designation of "AACFAS". If your status is "incomplete" or no status, you will not be awarded with the "AACFAS" designation.

Website Listing

Do you agree to list your name listed in the members directory on ACFAS.org? ☐ Yes ☐ No

Date of Birth ____/______/________ (Month/Day/Year)

Gender ☐ Male ☐ Female
(For demographic purposes only)

Certificate Upon approval of my application I would like my name printed on my Post-Graduate Fellow certificate as follows:

____, DPM, AACFAS
(Please Print Name)

Authorization *I authorize the College to make such inquiries and to obtain such information as it deems necessary or appropriate to evaluate my qualifications for membership. I understand that this information will remain confidential. I further authorize any hospital, any medical staff, any medical organization and any person, who may have information that the College deems relevant to its evaluation of my application, to provide such information to the College upon its request.*

By providing my name, telephone number, facsimile number(s), and e-mail address(es) and signing this form, I expressly consent to the delivery of communications promoting the commercial availability or quality of any events, goods, or services from the American College of Foot and Ankle Surgeons or its licensees or vendors, whether by facsimile, electronic mail, or regular mail. To the extent consent is given on behalf of an organization, I certify that I have authority to give such consent.

I will adhere to the By-Laws and Principles of Professional Conduct of the College.

____ ____________________
Applicant Signature (Required) Date

Post-Graduate Fellow Dues: $240 **October 1, 2024 – September 30, 2025** ***Please allow up to 14 business days for processing.***

☐ VISA ☐ MasterCard ☐ American Express or Check # __________ Amount Enclosed: **$240**

Credit Card Number: ______________________________ Exp Date: _____ /_____ Security Code: ______________

Name on Card: ________________________ Signature: ________________________ Date: __________

Completed application can be submitted by:

Upload to: https://www.acfas.org/membershipdropbox/

Fax to: (773) 444-1340 **Or mail to:** American College of Foot and Ankle Surgeons, PO Box 4528, Carol Stream, IL 60122-4528

Questions: Contact Madeline Giella at 773-444-1327 or maddy.giella@acfas.org.