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

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FootHealthFacts.org

ASSOCIATE MEMBER APPLICATION – 2024

Board Qualified status with the American Board of Foot and Ankle Surgery (ABFAS) is a requirement.

Application Type: ☐ New Associate ☐ Associate Reinstatement **ID#**: _____ Office Use

NPI Number: _____

ABFAS Board Qualified in: (PLEASE TYPE OR PRINT LEGIBLY)

☐ Foot Surgery (Foot Surgery Qualified meets requirement) _____(date)
☐ RRA Surgery _____(date)

Name:

First: _____ MI/Middle: _____ Last: _____ Suffix: _____

Previous Last Name (Change due to marriage, divorce, etc.): _____

Academic Degree Abbreviations: DPM, _____

Spouse Name: _____

Principal Office/Primary Address: *This mailing address will be used in the ACFAS directory and the FootHealthFacts.org website.*

Principal Office Name: _____

Address: _____

City: _____ ST/Province: _____ Zip: _____ Country: _____ (OTHER THAN USA)

Telephone: _____ Fax: _____

Website: _____

Primary Personal Email Address*: _____
**Email addresses do not appear in the ACFAS directory or FootHealthFacts.org.*

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Second Office Address: *This address will be used in the ACFAS directory and the FootHealthFacts.org website.*

Second Office Name: _____

Address: _____

City: _____ ST/Province: _____ Zip: _____ Country: _____ (OTHER THAN USA)

Telephone: _____ Fax: _____

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

Batch # _____ Approval # _____ Amount $ _____
Office Use

Application Expires on 9/30/2024

Applicant's Name: _____

Home Address:_____

City: _____ ST/Province: _____ Zip: _____ Country: _____
(OTHER THAN USA

Telephone: _____ Fax: _____ Mobile/Cell: _____

Secondary Email Address:_____

☐ Preferred Mail Address ☐ Preferred Billing Address (Check only if mail and/or billing is to go to this address)

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

Year Graduated: _____

Last Residency: ☐ PM&S-24 ☐ PM&S-36 ☐ PMSR ☐ PMSR/RRA
☐ PSR-12 ☐ PSR-24 ☐ PSR-24+ ☐ PSR-36 ☐ Other: _____

Last Residency (Hospital/Clinic) _____

Last Residency Director's Name _____

Year Residency Completed: _____

Fellowship (if applicable):

Fellowship Program Name: _____

Fellowship Director's Name: _____

Length of Fellowship: ☐ 6 mos or less ☐ 1 year ☐ 2 years ☐ Other _____

Year Fellowship Completed: _____

Practice Type: (Select only one)

☐ Private Practice ☐ Multi-Specialty Group ☐ Educational Institution
☐ Partnership ☐ Orthopedic Med/Sur Group ☐ Military
☐ Podiatric Med/Sur Group ☐ Hospital ☐ VA
☐ Other _____

Status in Practice: ☐ Owner ☐ Employee ☐ Partner
(Please check only one box)

State(s) in Which You Are Licensed to Practice: _____

Website Listing:

Do you agree to have your name listed in the Members-Only Directory on ACFAS.org and your principal office/primary address on the ACFAS consumer practicing marketing website **FootHealthFacts.org?** ☐ Yes ☐ No

Applicant's Name: _____

Date of Birth: ____/_____/_____ (Month/Day/Year) **Gender**: ☐ Male ☐ Female
(This section is for demographic purposes only)

Certificate:

Upon approval of my application I would like my name printed on my certificate as follows:
(Initial certificate included with membership. Additional certificates may be purchased. See payment information below.)

_____, DPM, AACFAS
(Please Print Name)

All certificates are delivered to your place of business. (See next page to purchase additional certificates.)

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.

_____ _____
Signature Required **Date**

Payment Information: ACFAS Membership Year is January 1 thru December 31. **Full Dues**: $650 **Full Tiered Dues**: $485

Tiered Dues Structure. Pro-rated dues by month application processed**.**
Applicants 3 years or less out of Residency or 2 years or less out of an approved Fellowship program:
Jan 2024: $485 **Mar 2024:** $405 **May 2024:** $330 **Jul 2024:** $245 **Sep 2024:** $165
Feb 2024: $445 **Apr 2024:** $365 **Jun 2024:** $285 **Aug 2024:** $200 **Oct 2024–Dec 2025: Pay 2025 Full Dues-**TBD

Applicants more than 3 years out of Residency. Pro-rated dues by month application processed**.**
Jan 2024: $650 **Mar 2024:** $545 **May 2024:** $435 **Jul 2024:** $330 **Sep 2024:** $215
Feb 2024: $595 **Apr 2024:** $485 **Jun 2024:** $380 **Aug 2024:** $270 **Oct 2024–Dec 2025: Pay 2025 Full Dues-**TBD

Application Processing fee: $95 unless ABFAS Board Qualified in Foot or RRA within 12 months of application processing.

Payment

Dues through 12/31/2024 (see above): $ _____
Application Processing Fee: $ 95* *waived if ABFAS Board Qualified in Foot or RRA in past 12 months
Additional Certificates ($40 each) *Optional*: $ _____
Total Enclosed or to be Charged: $ _____

Check No. _____ or ☐ VISA ☐ MasterCard ☐ American Express

Credit Card Number: _____ EXP DATE: ____ /____ Security Code: _____

Zip Code for Credit Card: _____

Name of Card Holder: _____

Signature: _____ Date: _____

Return by: **Upload to Membership Dropbox**: https://www.acfas.org/membershipdropbox/ **Fax**: 773-444-1340.
Mail: American College of Foot and Ankle Surgeons, PO Box 4528, Carol Stream, IL 60122-4528.

Questions: Contact Terry Wilkinson, PhD, CAE at 773-444-1301 or by email at terry.wilkinson@acfas.org. Canada and active duty military applicants, please contact for current rate.

Your application will be reviewed and you will receive a status response within two weeks of receipt.