



FLORIDA SOCIETY OF  
PLASTIC SURGEONS

## **APPLICATION for MEMBERSHIP**

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Complete the attached application and return it to: **Florida  
Society of Plastic Surgeons**  
**6300 Sagewood Drive, Suite H255**  
**Park City, UT 84098**  
**or Via e-mail to Susan Russell at [srussell@hdplanit.com](mailto:srussell@hdplanit.com)**

### **Your application must include the following:**

1. Curriculum Vitae or Biosketch
2. Current Photograph in jpeg format (high resolution please)
3. Application Fee of \$100 (current year dues will be billed upon election to membership)
4. A copy of all current Board Certifications
5. A copy of your current valid active license to practice medicine in Florida
6. A letter of verification of staff privileges from a local Florida hospital
7. Verification of ASPS or ASAPS status

When your application is reviewed for completeness, your name will be circulated to the members of the society, and your membership will then be voted on by the Board of Directors. An affirmative vote will activate your Candidate Status in the Society.

If you have any questions or need any further information, please do not hesitate to contact us. Our telephone number is 435-602-1326.

## **MEMBERSHIP ELIGIBILITY, REQUIREMENTS AND PRIVILEGES**

### **Excerpt from FSPS Bylaws, Chapter III, Membership:**

A. Members of the Society shall agree to abide by these BYLAWS and the Code of Ethics of the American Society of Plastic Surgeons, and maintain and fulfill their eligibility criteria for their category of membership. If a member of the Society fails to maintain eligibility for his or her category of membership, said membership shall be revoked or suspended at the discretion of the Board of Directors. Reinstatement of membership shall be at the discretion of the Board of Directors, following a determination that the criteria for membership have been met. The Board of Directors shall have the right to require reapplication of any past member whose membership had been revoked for failing to maintain and fulfill his or her eligibility requirements.

B. Categories of Membership. The Society shall have the following categories of membership:

- Candidate
- Active
- Life
- Inactive
- Corresponding
- Retired
- Courtesy
- Honorary

All applications for membership in the Society must be accompanied by a recent photograph of the applicant and an application fee in an amount to be determined from time to time by the Board of Directors.

#### **1. Candidate:**

a. Candidates must meet all the following criteria:

- i) Be Board Eligible or Certified by the American Board of Plastic Surgery or the Royal College of Physicians and Surgeons of Canada (and/or the Corporation Professionnelle Des Medecins du Quebec);
- ii) Be Candidate or Active members of either the American Society of Plastic Surgeons or the American Society for Aesthetic Plastic Surgery unless they are currently a Courtesy member of FSPS.
- iii) Hold an unrestricted, active, and non-probationary Florida license to practice medicine and surgery;
- iv) Hold full plastic surgery privileges on the staff of at least one local licensed Florida hospital;

b. Candidate status shall be limited to a term of not more than five (5) consecutive years, after which the member must be elevated to Active membership, reapply for Candidate status, or resign from the Society.

- c. Candidates shall pay dues, and may serve on committees. They may not vote or hold office.
- d. The names of all applicants for Candidate status shall be circulated by the Secretary to all Active and Life members in official Society publications and/or communications, inviting comments for a period of 30 days either in support of or objecting to the acceptance of an applicant for Candidate status. All comments will be included with the application for Board consideration. Receiving no comments will be considered approval by acclamation.
- e. Election to Candidate status shall be by at least four-fifths affirmative vote of the Board of Directors not less than 30 days after the applicant's name has been circulated to the membership.

## **2. Active:**

- a. Active members must meet all the following criteria:
  - i) Hold an unrestricted, active, and non-probationary Florida license to practice medicine and surgery.
  - ii) Be certified by the American Board of Plastic Surgery or the Royal College of Physicians and Surgeons of Canada in the specialty of Plastic Surgery.
  - iii) Be Active members in good standing of either the American Society of Plastic Surgeons, or the American Society for Aesthetic Plastic Surgery.
  - iv) Must have attended one meeting of the Florida Society of Plastic Surgeons prior to elevation to Active status.
  - v) Must have admitting privileges at one local licensed Florida hospital, and at a minimum, be credentialed at that same hospital to perform any and all procedures performed in any outpatient or office setting the member utilizes, and to treat complications arising from same.
- b. To qualify for election to Active membership, a Candidate must have attended at least one meeting of the Society since initial application was made. Attendance at the meeting at which the vote on their membership takes place will count toward this requirement.
- c. Upon recommendation by the Board of Directors, the names of all Candidates for Active membership shall be circulated by the Secretary to all Active and Life members in official Society publications and/or communications at least 30 days prior to the annual meeting of the Society.
- d. Election to Active membership status shall require the affirmative vote of at least four-fifths of the voting members present and voting at the annual meeting.
- e. Active members shall pay dues, may serve on committees, may vote, and may hold office.

This application will remain under active consideration for two years from date of receipt by FSPS. If Candidate Status has not been attained by that time, this application will be retired and will no longer be considered.

Application Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Mailing Address if different from above: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pre-Med School: \_\_\_\_\_ Year: \_\_\_\_\_ to Year: \_\_\_\_\_

Medical School: \_\_\_\_\_ Year: \_\_\_\_\_ to Year: \_\_\_\_\_

Residencies – Surgery \_\_\_\_\_ Year: \_\_\_\_\_ to Year: \_\_\_\_\_

Plastic Surgery \_\_\_\_\_ Year: \_\_\_\_\_ to Year: \_\_\_\_\_

Fellowships/Other \_\_\_\_\_ Year: \_\_\_\_\_ to Year: \_\_\_\_\_

FL Lic #: \_\_\_\_\_ Date Issued: \_\_\_\_\_ *(attach copy with application)*

Board Certifications: Plastic Surgery – include date: \_\_\_\_\_

Other Boards with date issued: \_\_\_\_\_

*(Must include a copy of all certifications with application)*

Are you a member of ASPS Yes No or The Aesthetic Society Yes No

*(Must include copy of letter of approval or copy of certificate)*

Are you a member of any of the following organizations: FMA AMA SESPRS

List any other organization memberships: \_\_\_\_\_

FL Hospital Appointments: \_\_\_\_\_

Name of FSPS Member who recruited me (if applicable): \_\_\_\_\_

**Please Answer YES or NO to the Following Questions:**

Has your license to practice medicine in any State, your license to prescribe drugs or your permit to dispense drugs, ever been revoked, suspended, restricted in any way, limited or voluntarily relinquished? **Yes**      **No**

**If so, please attach a separate report stating the date such action was taken, the name of the Agency, the case or matter number and give a precise description of the circumstances and the final action taken.**

Have you ever been notified to respond to or appear before a County or State Medical Society, Board or Committee of a hospital, any other Health Care facility on a complaint of any nature, including but not limited to unprofessional or unethical conduct and have been found guilty? **Yes**      **No**

**If so, please attach a separate report stating the date of actual notice, the organization or entity, and provide a detailed description of the circumstances and the nature of the complaint or charge and the final disposition.**

Have your privileges at any hospital or other health care facility ever been revoked, suspended, limited involuntarily, denied or not renewed by such institution? **Yes**      **No**

**If so, please attach a separate report stating the date such action was taken, the name of the entity, description of the action taken, the basis given.**

Has your license to practice medicine in any State, your privileges, either staff or clinical, ever been placed on probation and/or limited in any respect by such entity? **Yes**      **No**

**If so, please attach a separate report stating the date such action was taken, the name of the entity, the basis such action was taken, its duration and the date of termination if applicable.**

In the past 10 years, have you been found guilty of medical malpractice, or agreed to a monetary settlement of a malpractice claim? **Yes**      **No**

**If yes, please attach a separate report stating the date of such notice and/or suit, the name of the Plaintiff(s), the city and State of the Plaintiff's residence when under your care, the alleged basis for such a claim, and the disposition; if settled or if a verdict was rendered, the amount, the name of the Court having jurisdiction over the claim and the case number if suit was filed.**

Have you ever been treated by any health care provider, in a formal or practice setting or informally, for alcohol or any substance abuse, including narcotics, central nervous systems, stimulants or depressants? **Yes**      **No**

**If so, please attach a separate report stating the details and the outcome.**

**The information in this application is provided for the purpose of obtaining membership in the Florida Society of Plastic Surgeons and, to the best of my knowledge, is accurate and complete.** If this application is accepted and membership is granted, I agree that requesting and accepting such membership, and continuing to maintain such membership, constitutes my consent to receive all communications sent by or on behalf of the Florida Society of Plastic Surgeons, Inc., and its subsidiaries and affiliates, via the communications vehicle of its preference, including but not limited to Email, Fax, Telephone, Regular Mail, or special expedited mail services.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

PRINT FULL NAME: \_\_\_\_\_

**RELEASE TO OBTAIN INFORMATION:** I authorize the Florida Society of Plastic Surgeons to consult with other organizations with which I have been associated, and with others who may have information bearing on my competence, character and ethical qualifications. I consent to the Society's inspection of such documents that may be material to an evaluation of my professional qualifications for membership, as well as my moral and ethical qualifications, and release from any liability all representatives of the Society for their acts performed without intentional fraud in connection with evaluating me and my credentials, and release from liability all individuals and organizations who provide information to the Society without intentional fraud concerning my competence, ethics, character and other qualifications for membership, including otherwise privileged or confidential information.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

# Membership Application Payment Form

Application Fee \$100

Payment can be made by Credit Card or Check

Credit Card Information:
Name (as appears on card): _____
Credit Card Number: _____
Exp: _____ CVV: _____
Email: _____

Check Information:
Make Payable to:
Florida Society of Plastic Surgeons or FSPS
Mail To:
6300 Sagewood Drive H255
Park City, UT 84098

