



# Florida Society of Thoracic & Cardiovascular Surgeons

5101 Ortega Blvd ~ Jacksonville, FL 32210

Phone 904-356-9300 ~ Fax 904-671-6131

www.fstcs.org ~ [Bridget@fstcs.org](mailto:Bridget@fstcs.org)

## Qualifications for membership in the Florida Society of Thoracic & Cardiovascular Surgeons:

### ACTIVE MEMBERSHIP- Annual dues \$500 (Payable upon acceptance)

- Certification from the American Board of Thoracic Surgery
- Established in the practice of thoracic and cardiovascular surgery for a minimum of two (2) years in the state of Florida.
- Provide names of two FL licensed thoracic/cardiovascular surgeons outside your own group who will provide references for this application. **\*One must be a current FSTCS Member**

### ASSOCIATE MEMBERSHIP - Annual dues \$450 (Payable upon acceptance)

- Have completed training in an approved thoracic and cardiovascular residency program
- Are in the process of acquiring certification
- Are licensed to practice in the State of Florida
- Provide names of two FL licensed thoracic/cardiovascular surgeons outside your own group who will provide references for this application. **\*One must be a current FSTCS Member**

### To apply for membership, simply complete and return the following:

1. The attached Application for Membership
2. A copy of your CV and
3. The \$50 application fee

By Mail:

Florida Society of Thoracic & Cardiovascular Surgeons  
5101 Ortega Blvd  
Jacksonville, Florida 32210

By fax: (904) 671-6131

By email: [Bridget@fstcs.org](mailto:Bridget@fstcs.org)

<b>\$50 APPLICATION FEE</b>		
METHOD OF PAYMENT:		
<input type="checkbox"/> Check # _____ Make payable to FSTCS <input type="checkbox"/> AMEX <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa		
Account #	Exp Date	CVV#
Cardholder Name		
Cardholder Phone #		
Credit Card Billing Address (include zip)		
Signature		



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## Application for Membership

Active Member

Associate Member

Name:

Last

First

Middle

Office Address:

Street

City

Zip

Phone #:

Fax #:

Place of Birth:

Date of Birth:

Spouse's Name:

E-Mail address:

### Education/Experience

### School/Location

### Dates

Premedical Education		
Medical Education		
Internship		
Residency/Other Graduate		
Practice Experience (since residency)		
(attach addition sheet if necessary)		

### Board Certifications

### Date of Certificate

### Certificate Number

American Board of Surgery		
Board of Thoracic Surgery		
Royal College of Surgeons		
Other Professional Memberships (attach additional sheet if necessary)		

Date licensed to practice in Florida

(must be 2 years for Active Membership): \_\_\_\_\_

Medical License #: \_\_\_\_\_

List two FL licensed thoracic/cardiovascular surgeons outside your own group who will provide references for this application. **\*One must be a current FSTCS Member** (Membership list available upon request)

1. \_\_\_\_\_

2. \_\_\_\_\_

Signature: \_\_\_\_\_

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