

SOUTHERN SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION
Application for Membership

NAME _____

BUSINESS ADDRESS _____

(number and street)

_____ (city, state, zip)

BUSINESS PHONE _____ FAX _____

EMAIL _____ HOME PHONE _____

MEDICAL EDUCATION

COLLEGE _____

DEGREE RECEIVED _____ YEARS ATTENDED _____

INTERNSHIP

HOSPITAL _____

DATES ATTENDED _____

RESIDENCY

HOSPITAL _____

_____ (number, street, city, state, zip)

DATES ATTENDED _____

SPECIALTY _____

CHAIRMAN OF DEPARTMENT _____

BOARD CERTIFICATION _____

(name of Board)

_____ (year certified)

MEDICAL LICENSE _____

(state)

_____ (year)

HOSPITAL APPOINTMENTS:

MEMBERSHIP IN LEARNED SOCIETIES:

MEDICAL SCHOOL FACULTY APPOINTMENT:

_____ (name of school)

_____ (department)

_____ (academic rank)

Signature and Date

Please include a check for \$100.00, written to SSPMR. This will be your application fee and dues for the year in which you join. Mail to PO Box 330298, Atlantic Beach, FL 32233-0298 Questions: 904 270 8886