ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

ACOG

The American Congress of Obstetricians and Gynecologists
409 12th Street, SW
P.O. Box 70620 • Washington, DC 20024-9998 • (202) 863-2455
and
The American College of Obstetricians and Gynecologists

INSTRUCTIONS FOR ASSOCIATE MEMBER INTERNATIONAL APPLICANT

Processing begins upon receipt of a **completed** application, including the processing fee.

1. Fill out pages 1 & 2. Please print in English with black ink or type.
2. Applicant must sign and date application under the "Signature of Applicant".
3. Applicants are required to pay an application fee of $335.00(U.S). This fee must be submitted with the application and is not refundable.
4. MAIL COMPLETED APPLICATION TO:

   ACOG, Membership Services Dept.
   409 12th St., SW
   Washington, DC 20024-9998

QUALIFICATIONS:

- A physician, outside the geographic confines of the Congress, who has given valuable service in obstetrics and/or gynecology and who is not eligible to be a Fellow or Junior Fellow.

- Demonstrates evidence of advanced training in women's health and be a member of an ob-gyn society or an organization recognized by the International Federation of Gynecology and Obstetrics (FIGO). Proof of membership is required.

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APPLICATION FOR

ASSOCIATE MEMBER INTERNATIONAL

PLEASE PRINT IN BLACK INK OR TYPE
NAME AS YOU WISH IT TO APPEAR ON ALL DOCUMENTS, MAILINGS, ETC.

NAME_____
First Middle Last Title

ADDRESS_____

_____

CITY _____ ZIP/POSTAL CODE_____

COUNTRY _____ PHONE NO. _____

DATE OF BIRTH _____/_____/_____ GENDER ☐ MALE ☐ FEMALE
month day year

E-MAIL ADDRESS* _____

*If you **do not** wish to receive emails covering current issues, please respond by checking this box ☐

BOARD CERTIFICATION ☐ No ☐Yes (if yes, please include a copy of your certification)

PLEASE SPECIFY BOARD _____

DATE CERTIFIED _____ EXPIRATION DATE _____

NOTICE: **EVIDENCE OF MEMBERSHIP IN AN OB-GYN SOCIETY OR ORGANIZATION IN YOUR COUNTRY, WHICH IS A MEMBER OF FIGO, MUST BE INCLUDED WITH APPLICATION BEFORE PROCESSING CAN BEGIN.**

MEDICAL SOCIETY AFFILIATION

_____

Medical College

_____

Institution Degree received Year

Primary Practice	Type of Practice	Group Practice		
_____	_____	_____	_____ Month Year	_____ Month Year
_____	_____	_____	_____ Month Year	_____ Month Year

Certification and Authorization

I certify that all information contained in the application for membership as an Associate Member International of The American Congress of Obstetricians and Gynecologists and The American College of Obstetricians and Gynecologists (collectively referred to as "ACOG") is true and accurate. I hereby acknowledge and agree that ACOG may review and assess my moral, ethical, and professional standing in evaluating this application for membership, and if admitted, for my continued membership. Furthermore, I hereby authorize ACOG to make any and all inquiries it deems necessary to evaluate this application. I further agree that I shall have no right to be informed of the identity of the persons or institutions from which information has been requested or received and that all information furnished to ACOG in connection with this application process shall be confidential and not subject to examination by me or by anyone acting on my behalf. I agree that ACOG has the sole discretion to determine my fitness to be an Associate Member International of ACOG. If my application is not acted upon favorably, I agree that I shall not hold ACOG, their officers, members or employees legally responsible for such action.

Pledge

If admitted as an Associate Member International, I pledge to abide by the bylaws and the Code of Professional Ethics of The American Congress of Obstetricians and Gynecologists and The American College of Obstetricians and Gynecologists, as they may be revised from time to time. Furthermore, I agree to notify ACOG immediately if there has been any adverse action taken against my medical license in any jurisdiction.

SIGNATURE OF APPLICANT _____ DATE _____

FOR OFFICE USE ONLY

Date Application Received _____ Date Fee Received _____

Amount Received _____

Missing Information Dates: