ACOG

The American Congress of Obstetricians and Gynecologists
409 12th Street, SW
P.O. Box 70620 • Washington, DC 20024-9998 • (202) 863-2406
and
The American College of Obstetricians and Gynecologists

JUNIOR FELLOW APPLICATION

NAME AS YOU WISH IT TO APPEAR ON ALL ACOG DOCUMENTS, MAILINGS, ETC.

NAME _____
First Middle Last

ADDRESS_____

CITY _____ STATE/PROVINCE _____ COUNTY (*if in U.S.*) _____

ZIP CODE/POSTAL_____ COUNTRY (*if outside U.S.*) _____

E-MAIL ADDRESS _____ PHONE NO. (____)_____

If you **do not** wish to receive these notifications, please respond by checking this box ☐

CITIZENSHIP _____ DATE OF BIRTH ____/____/____ GENDER ☐ MALE ☐ FEMALE
Month Day Year

CURRENT ACTIVE DUTY MILITARY? ☐ No ☐ Yes RANK _____ BRANCH OF SERVICE _____

SOCIAL SECURITY NO. _____-____-_____ MEDICAL LICENSE(S): STATE(S)/PROVINCE(S) _____

LICENSE NUMBER(S) _____

HAVE YOU EVER SURRENDERED YOUR MEDICAL LICENSE OR HAS YOUR MEDICAL LICENSE EVER BEEN REVOKED, SUSPENDED, RESTRICTED OR SUBJECTED TO ANY OTHER ADVERSE ACTION?
☐ NO ☐ YES If yes, please provide details on a separate page.

Include below a chronological history of events describing all current and past internships, residencies and fellowships*(required)*:

Training/Type of Prof. Act.	Hospital/Program Location (City, State)	Date Started	Date Completed or Anticipated Completion Date

NOTE: If there is a break in the chronology above, please use a separate sheet to indicate type of activity, place and date. *(Required)*

TOTAL TIME IN OBSTETRICS & GYNECOLOGY: _____ MONTHS _____ YEARS

HOSPITAL STAFF POSITIONS:

Primary: Institution _____ ☐Active Staff ☐Courtesy Staff City/State or Province_____

Start Date ___ /___/___ End Date ___ /___/___ Phone No. _____ Name of Hospital Administrator _____

Chief of Ob-Gyn _____ Chief of Staff _____

HAVE YOU EVER HAD HOSPITAL STAFF PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED OR SUBJECTED TO ANY OTHER ADVERSE ACTION? ☐ NO ☐ YES If yes, please provide details on a separate page.

RESIDENCY PROGRAM DIRECTOR VERIFICATION STATEMENT

Candidate for JUNIOR FELLOW

Candidate's Current Level in Program _____

Completion Date or Anticipated Completion Date of Program _____/ _____
Month *Year*

Residency Program Name as Specified by the RRC _____

Program Director's Name (please print) _____

Program Director's Signature _____

Program Director's Daytime Phone No. (____)_____

If the Program Director is an active Fellow and from the same District as the candidate, please disregard the Proposer's endorsement.
NOTE: If you are out of residency, the name and signature of the Program Director are still needed for verification purposes.

CANDIDATE'S PROPOSER, PLEASE COMPLETE THE FOLLOWING:

The proposer must be a **Fellow** of The American Congress of Obstetricians and Gynecologists and from the same District (exception: applicants from the Armed Forces) as the applicant. (The bylaws describe the geographical area included in each district.).

I, being a Fellow in good standing of the American Congress of Obstetricians and Gynecologists, and the American College of Obstetricians and Gynecologists and from the same district as the candidate (exception: applicants from the Armed Forces) desire to propose this candidate for JUNIOR FELLOWSHIP. I have known the candidate for _____ years and/or months.

_____ FACOG _____
Proposer's Signature (required) *Type or Print Name of Proposer (required)*

_____ _____/_____/_____ _____
City and State/Province *Date* *ACOG Member ID Number*

Certification and Authorization

I certify that all information contained in the application for membership as a Junior Fellow 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 the 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 a Junior Fellow 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 a Junior Fellow of ACOG, 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 _____

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INSTRUCTIONS FOR JUNIOR FELLOW APPLICANT

Processing begins upon receipt of a completed application.

1) FILL OUT APPLICATION COMPLETELY. **PLEASE PRINT IN BLACK INK OR TYPE.**

2) APPLICANT'S SIGNATURE MUST APPEAR ON PAGE 2.

3) THE PROGRAM DIRECTOR VERIFICATION STATEMENT ON PAGE 2 MUST BE COMPLETED AND SIGNED BY THE CHIEF OF YOUR OB-GYN RESIDENCY PROGRAM. Program Director, if a Fellow in good standing from your district, may serve as your proposer. (***NOTE: If you are out of residency, the name and signature of the Program Director are still needed for verification purposes).***

4) THE PROPOSER MUST BE A **FELLOW** OF ACOG AND FROM THE SAME DISTRICT AS THE APPLICANT. APPLICANTS APPLYING WITHIN THE ARMED FORCES DISTRICT MAY OBTAIN A PROPOSER (WHO IS A FELLOW) FROM WITHIN OR OUTSIDE THE ACOG ARMED FORCES DISTRICT.

5) MAIL COMPLETED APPLICATION TO:

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

FOR OFFICE USE ONLY:

Date Application Received _____

Missing Information Dates