

Suffolk Pediatric Society Application

Name: _____ Send Mail to: Office

Date of Birth: __ __ / __ __ / 19 __ __ Home

Office:

Address: _____

Phone: (____) - _____ Fax: (____) - _____ E-mail: _____

Home:

Address: _____

Phone: (____) - _____ Fax: (____) - _____ E-mail: _____

Type of Membership applied for: Regular (\$150) Resident (\$75)

Calendar Year Dues (Check must be enclosed): \$ _____

EDUCATION:

Dates:

College: _____

Medical School: _____

Post Graduate Training: _____

Hospital Affiliation(s): _____

Board Eligibility: _____

Board Certification: _____

Board Recertification: _____

F.A.A.P.: Yes Date: _____ No

Member of New York State Medical Society: Yes No

Type of Practice: Subspecialty (type): _____
General Pediatrics

Sponsors (two): _____

I hereby apply for membership in the Suffolk Pediatric Society:

Date

Signature

Attach recent photo and mail application to the SPS Secretary:
Laurene Fleischer, MD, FAAP
205 East Main Street, Suite 2-8
Huntington, NY 11746