



**New York Society for
Thoracic Surgery Inc.**
Founded 1917



Application for Membership (please fill out completely)

Name: _____
Last
First
MI
Degree

Date of Birth: ____/____/____
Mo
/
Day
/
Year

Current Hospital Affiliations _____

Current Academic Affiliation and Title (if applicable): _____

Mailing Address: _____

Office Phone: () _____ Mobile: () _____

Email (print): _____

Administrative Email (print): _____

Membership in Other Surgical Societies

Membership Type (Circle One): Active Associate Junior

Sponsoring NYSTS Members: (three required)

1. _____
Name
Address
or email endorsement sent to nysts@nysts.org

Signature

2. _____
Name
Address
or email endorsement sent to nysts@nysts.org

Signature

3. _____
Name
Address
or email endorsement sent to nysts@nysts.org

Signature

SIGNATURE OF APPLICANT

DATE OF APPLICATION

Please email to nysts@nysts.org