



# ACADEMY OF SURGICAL RESEARCH

# Membership Application

Name		Degrees	
Affiliation		Position	
Address 1			
Address 2			
City, State, Zip			Country if other than USA
Phone		Fax	
Email			
Surgical Specialty		Surgical Sub-Specialty	

### How did you hear about ASR?

References: Please list two peer professional who are familiar with your field of interest:

Name	Name
Affiliation	Affiliation
Phone	Phone

<b>Membership Type:</b> <input type="checkbox"/> Individual \$295  <input type="checkbox"/> Associate \$150	<b>Associate Membership Verification:</b> I attest the applicant is a full-time, degree seeking student or a resident in training program actively involved in surgical research
	Signature of advisor or department chair
	Printed Name
	Telephone

<input type="checkbox"/> Check	Credit Card: <input type="checkbox"/> American Express <input type="checkbox"/> Master Card <input type="checkbox"/> Visa <input type="checkbox"/> Discover	
Check Number	Card Number	Expiration Date
Amount (US Dollars Only)	Cardholder Billing Address	Card Code

<i>Checks must be in U.S. dollars and drawn on a U.S. bank and made payable to the Academy of Surgical Research.</i>	City, State, Zip
	Please print out form and remit to: <b>ASR Member Services</b> 15490 – 101 <sup>st</sup> Ave N, Suite 100 Maple Grove, MN 55369 Phone: 763.235.6464 Fax: 763.235.6461

To submit this form via our Secure Data site, first fill out the form and save it to your desktop then go to [Secure Data Upload website](https://lock.securedataupload.com) or <https://lock.securedataupload.com>. Log in with user name **asr** and password **as321** (password is case sensitive) *Skip directly to Step 3!* Click the Browse button to locate your completed registration on your computer, then click the Upload button to submit your completed form.