



# ASIAN ASSOCIATION OF PEDIATRIC SURGEONS

## APPLICATION FORM FOR MEMBERSHIP

**Please TYPE or Write in Bold Capitals**

### REQUIREMENTS FOR MEMBERSHIP:

- Complete this Form
- Obtain a letter of recommendation from your sponsoring members (2)
- Send the above 3 documents along with your *Curriculum vitae with bibliography* to the Secretary General (address is at the bottom of page 2).
- You will be asked to pay the membership fee of US\$200 when the Secretary has approved and is satisfied with your application.
- Please send the filled up application form to the E-Mail: [secretariat\\_aaps@hotmail.com](mailto:secretariat_aaps@hotmail.com)

### I. GENERAL INFORMATION

(Last Name)

(Middle Name)

(First Name)

Country of Residence:  Nationality:  Date of Birth:

*please check the preferred mailing address*

Office Address:

Home Address:

Tel:

Tel:

Fax:

Fax:

E-Mail Address:

### II. CLINICAL SPECIALITY

Pediatric Surgery:  Pediatric Surgery & General Surgery:  Pediatric Urology:

Pediatric Thoracic Surgery:  Other (please specify):

**III. NAMES & ADDRESSES OF SPONSORING MEMBERS (2 PERSONS)**

A. Name:

Address:

Signature:

Date:

B. Name:

Address:

Signature:

Date:

**SIGNATURE OF APPLICANT**

(Signature)

(Date)

***FOR AAPS OFFICE USE:***

APPLICATION RECEIVED BY AAPS SECRETARY

\_\_\_\_\_ Date \_\_\_\_\_

SPONSORING LETTERS RECEIVED

\_\_\_\_\_ Date \_\_\_\_\_

APPROVED BY EXECUTIVE BOARD

\_\_\_\_\_ Date \_\_\_\_\_

APPROVED BY COUNCIL

\_\_\_\_\_ Date \_\_\_\_\_

CERTIFICATE MAILED TO APPLICANT

\_\_\_\_\_ Date \_\_\_\_\_

REGULAR MEMBERSHIP \_\_\_\_\_ / ASSOCIATE MEMBERSHIP \_\_\_\_\_

ENROLLMENT FEE \_\_\_\_\_ DATE RECEIVE \_\_\_\_\_ RECEIPT # \_\_\_\_\_

**Secretary General**

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