



Application for Membership

Active Member

Membership Criteria Checklist

- ☐ Board certified and/or licensed practicing physicians or surgeons of related disciplines

Submission Requirements Checklist

- ☐ Completed application form including signature
- ☐ One signed letter or email of sponsorship from the current ISTTT active board member
- ☐ Current Curriculum Vitae
- ☐ Digital color professional photo
 - Annual Dues: 100 USD
 - Submission Deadlines: Applications are accepted throughout the year via email or mail. The ISTTT Board of Directors approves applications on a monthly rolling basis.

DEMOGRAPHICS:

PLEASE PRINT. (All information must be provided in English.)

Name: _____

 Last Middle First Suffix

Degree: ☐ MD ☐ DO ☐ DPM ☐ MBBS Other: _____

Date of Birth: / / (mm/dd/yyyy)

Gender: ☐ Male ☐ Female ☐ Prefer Not to Answer

Race: ☐ Asian ☐ African ☐ Hispano/Latino ☐ Middle Eastern / North African ☐ White ☐ None of the above ☐ Prefer Not to Answer

Practice Type: ☐ Solo ☐ Single Specialty Group ☐ Multi-Specialty Group ☐ Full-time employee of medical school / University ☐ Other

Year Entered Practice: _____

Preferred Mailing Address: ☐ Office ☐ Home

Primary Email Address: ☐ Office ☐ Home

OFFICE CONTACT INFORMATION

Practice/University/Facility Name:

Department:

Job Title: _____

Street Address:

City: _____

State/Province: _____

Zip/Postal Code: _____

Country: _____

Phone:

Country code City code Area Code Number

Email: _____

HOME CONTACT INFORMATION

Street Address: _____

Apartment or Unit: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Country: _____

Phone: _____

Country code City code Area Code Number

Cell phone: _____

Email: _____

Colleague Contact: ISTTT members may log in to the members only section of the website to obtain colleague contact information including work address and email and home and cell phone numbers if permitted for release.

☐ Check here if you DO NOT want your email made available to ISTTT members

☐ Check here if you DO NOT want your phone numbers available to ISTTT members

EDUCATION AND TRAINING

Name of Medical School: _____ Year of Graduation: _____

City, State (Province), Country: _____

Medical or Surgical Specialty:

☐ Orthopedic Surgery ☐ Podiatry ☐ Plastic Surgery ☐ Vascular Surgery ☐ Family medicine ☐ Radiology ☐ Hematology ☐ Infectious Disease ☐ Endocrinology ☐ Diabetology ☐ Internal Medicine ☐ Other

Residency Training:

Program/Institution Name: _____

Year of complete: _____

City, State/province, Country: _____

Fellowship (if applicable)

Program/Institution Name: _____

Year of completion: _____

City, State/province, Country: _____

PROFESSIONAL EXPERIENCE:

Practicing Years: _____

Board Certification Years: _____

Board Certification Title & Country of Certification:

Teaching:

☐ Yes

☐ No

Researching Clinical or Basic Science:

☐ Yes

☐ No

SPONSORSHIP

A CURRENT ISTTT ACTIVE BOARD MEMBER MUST PROVIDE A LETTER OR EMAIL OF SPONSORSHIP ON YOUR BEHAVE.

SPONSOR NAME: _____

Letter of sponsorship should be signed and sent directly by its author to ISTTT via email:

Email: info@ISTTT.org

AGREEMENT

By signing below, I attest that above information is true. I understand that completion and submission of this application form provides written permission for the ISTTT to make inquiries and investigate as it deems necessary to verify my credentials and professional standing.

Signature: _____ Date: MM/DD/YYYY

SUBMISSION

Please submit the application and other application material identified in the submission requirement checklist on the first page of this application to ISTTT via email.

Email: info@ISTTT.org

Upon receipt of all application requirements, your documents will be reviewed by the ISTTT board and then your name will be presented for final approval to the board of directors. You will be informed of the review progress as it proceeds and notified when our membership has been approved. At that time, your due notice and link for payment will be sent and your member benefits will begin.