



# ASGE International Membership

*Group membership for International Physicians*

## Solutions for the entire GI Team!

Further details about eligibility requirements for active membership can be found at [www.asge.org/join](http://www.asge.org/join).

**Group Membership Dues: One-time initiation fee of \$100 is waived Annual Dues: \$385.00.**

\* Please note refunds will NOT be granted if application is not completed within 45 days of submission.

Questions? Contact your ASGE Customer Care Team at [membership@asge.org](mailto:membership@asge.org) or call 630-573-0600.

### International Member Benefits

Below are just some of the benefits, included with your membership dues. We appreciate the opportunity to serve you and to be your partner in the delivery of high-quality GI healthcare.

For a complete list of benefits please visit our website at [www.ASGE.org](http://www.ASGE.org).

- Access GILEAP for flexible, cutting-edge online learning content
- Stay current with subscriptions to ASGE publications, *GIE*®, *SCOPE*, and *Leading Edge*
- Manage your practice effectively and profitably with access to ASGE practice management resources
- Save money with members-only discounts on course registration fees and products (i.e. ASGE Postgraduate Course, DDW registration, and other ASGE courses offered throughout the year)
- Optimize patient care with online access to valuable Practice Guidelines and Technology Reviews
- Be innovative, with access to ASGE endoscopic research funding opportunities

### Join ASGE and save on over \$4,700 on tangible benefits!

Benefits	Savings
GIE®	\$ 350
DDW®Discount/ APG Course	\$ 625
Complimentary GILEAP online content	\$3,750
<b>Total Savings</b>	<b>\$4,725</b>

Add to the savings when you receive member discounts of up to 20% on select DVDs, educational products and ASGE course registrations!

\*\*Please submit one application for each new member.



# ASGE International Sponsor Endorsement Form

To apply for International membership, the candidate must be sponsored by one current ASGE member (Active or Senior). The sponsor section below is to be completed by your sponsor and submitted via fax to 630.963.8332, e-mail to [membership@asge.org](mailto:membership@asge.org) or mailed to 3300 Woodcreek Road, Downers Grove IL 60515. Questions? Contact your ASGE Customer Care Team via email at [membership@asge.org](mailto:membership@asge.org) or call 630-573-0600.

Date: \_\_\_\_\_

### Candidate Information

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Job Title \_\_\_\_\_ Current Degrees(s)  MD  DO Other \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

### Sponsor Information

*The information below is to be completed by your sponsor.*

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Job Title \_\_\_\_\_ Current Degrees(s)  MD  DO Other \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

### Basis for evaluation (Please select all that apply)

- Director of endoscopic training program
- ASGE member familiar with applicant's clinical and endoscopic skills

### Evaluation

Patient clinical skills/judgment  adequate  inadequate  cannot evaluate  
 Endoscopic skills  adequate  inadequate  cannot evaluate

- I recommend
- I do not recommend for ASGE membership

Sponsor's Signature \_\_\_\_\_



# Active Membership

Date: \_\_\_\_\_

## Personal Information

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

Suffix \_\_\_\_\_ Position Title \_\_\_\_\_ Current Degrees(s)  MD  DO Other \_\_\_\_\_

**Demographics** (Optional - collected for statistical purposes only-please choose **any** with which you identify)

### Race:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> American Indian                  | <input type="checkbox"/> Asian                              | <input type="checkbox"/> Black (African)             |
| <input type="checkbox"/> Black (Caribbean)                | <input type="checkbox"/> Black (American)                   | <input type="checkbox"/> Caucasian/White             |
| <input type="checkbox"/> Hispanic/Latino (American)       | <input type="checkbox"/> Hispanic/Latino (Central American) | <input type="checkbox"/> Hispanic/Latino (Caribbean) |
| <input type="checkbox"/> Hispanic/Latino (South American) | <input type="checkbox"/> Hispanic/Latino (European)         | <input type="checkbox"/> Native Alaskan              |
| <input type="checkbox"/> Native Hawaiian                  | <input type="checkbox"/> Pacific Islander                   | <input type="checkbox"/> Multiracial _____           |
| <input type="checkbox"/> Other _____                      | <input type="checkbox"/> Prefer not to answer               |  |

### Do you consider yourself:

- Female  Male  Transgender  Prefer not to answer

**Date of Birth** \_\_\_\_\_ (MM/DD/YYYY)

Preferred Mailing Address  Work  Home Preferred E-mail Address  Work  Home

Institution Name \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Work Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Fax \_\_\_\_\_ E-mail \_\_\_\_\_

## Education

Please provide **institution name, degree awarded, and date awarded** for the following:

Medical School:

Institution: \_\_\_\_\_

Degree Awarded: \_\_\_\_\_ Date Awarded: \_\_\_\_\_



Please **provide type, institution name, program director's name and inclusive dates** for the following:

Fellowship/Endoscopic Training:

Institution: \_\_\_\_\_

Program Director: \_\_\_\_\_

Inclusive Dates: \_\_\_\_\_

**Medical Licensure**

State/Country \_\_\_\_\_ Registry # \_\_\_\_\_

**NPI Number** \_\_\_\_\_

(In compliance with Federal Government Sunshine Act, implemented on August 1, 2013, we are required to obtain all National Provider Identification (NPI) Numbers.)

**If Board Certified in GI, no sponsorship endorsement form is needed. Please include your certification information.**

IM Specialty Board - Certification Date of Expiration: \_\_\_\_\_

GI Specialty Board - Certification Date of Expiration: \_\_\_\_\_

**Practice and Professional Information**

**Endoscopy Experience in the last 12 months and / or Numbers Performed during Training (approximate)**

	Dates	Number Performed
Upper GI	_____	_____
Colonoscopy	_____	_____
ERCP	_____	_____
EUS	_____	_____
Enteroscopy	_____	_____

**Practice Environment**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Corporate/Industry                  | <input type="checkbox"/> GI group hospital - employee       | <input type="checkbox"/> GI group private practice - employee  |
| <input type="checkbox"/> GI group private practice - partner | <input type="checkbox"/> Government VA hosp/med cntr        | <input type="checkbox"/> Multi-specialty group – hosp employee |
| <input type="checkbox"/> Multi-spec grp-prvte prctc-empl     | <input type="checkbox"/> Multi-spec grp-prvte prctc-partner | <input type="checkbox"/> Solo practice                         |
| <input type="checkbox"/> Staff model HMO                     | <input type="checkbox"/> University based group             | <input type="checkbox"/> Other (employee)                      |
| <input type="checkbox"/> Other (independent contractor)      |   |  |



**Reasons for joining the Society (all that apply)**

- Education
- Practice Benchmarking Survey
- Access to members only web site
- Other \_\_\_\_\_
- Advocacy/Legislation
- GIE
- Endoscopy Unit Recognition Program
- Access to Research Awards/funding
- Reduced DDW Registration

I authorize the American Society for Gastrointestinal Endoscopy to obtain information from societies, hospital staff, members and any other source regarding this application and my qualifications for membership, which information, whether or not solicited by the Society, will be kept confidential by the Society.

I certify that the above information is accurate (signature) \_\_\_\_\_

For payment of membership dues, we accept Visa, MasterCard, American Express, Discover, or a check.  
**\*\* Please note refunds will NOT be granted if application is not completed within 45 days of submission\*\***

**Personal Information**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

**Payment (U.S. Dollars)**

Membership period is Jan 1. – Dec. 31. Annual dues for following year will be prorated based on acceptance date.  
**\* Proration of dues applies to new members only. Please note refunds will NOT be granted if application is not completed within 45 days of submission.**

**Membership Amount Due: \$385:** This waives the a one- time \$100.00 initiation fee.

A Check is enclosed in U.S. dollars, payable to ASGE. Amount \_\_\_\_\_

Visa  MasterCard  American Express  Discover

Card Number \_\_\_\_\_ Name on Card \_\_\_\_\_

Expiration Date \_\_\_\_\_ Amount \_\_\_\_\_ Signature \_\_\_\_\_  
MM/YY Please print

Association for Bariatric Endoscopy (ABE) – members of ASGE can join for an additional \$100.00

**Join a SIG today! –only \$25 each for 1 year\***

- Ambulatory Endoscopy Center (AEC)
- ASGE Women in Endoscopy (AWE)
- Endoluminal Therapy for Esophageal Disease/ Gastroesophageal Reflux Disease (ETED/GERD)
- Endoscopic Retrograde Cholangiopancreatography (ERCP)
- Endoscopic Ultrasonography (EUS)
- Invention & Innovation (II)
- Small Bowel Endoscopy / Capsule Endoscopy (SBE/CE)
- Interventional IBD (IIBD)
- Intraductal Endoscopy and Cholangiopancreatography (IECP)
- Endoscopic Submucosal Dissection (ESD)
- Intraductal Endoscopy and Cholangiopancreatography (IECP)
- Latin American GE (LATAM)

**Submit** completed application and payment

**Mail:** ASGE  
3300 Woodcreek Drive  
Downers Grove, IL 60515

**Apply Online:** [www.ASGE.org/membership](http://www.ASGE.org/membership)

**Fax:** 630.963.8332