

**APPLICATION FOR MEMBERSHIP  
To  
Western Trauma Association**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ADDRESS:**

Office: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 \_\_\_\_\_ Fax: \_\_\_\_\_  
 Home: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 \_\_\_\_\_

Spouse's Name: \_\_\_\_\_  
 Children' (Name(s) &  
 Ages: \_\_\_\_\_

**Pre-Medical Education**

Institution	Degree	Year

**Medical Education**

Institution	Degree	Year

**Internship/Residency**

Institution	Degree	Year

**Board Certification**

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

**Signature of Western Trauma Sponsoring Member:** \_\_\_\_\_

**Western Trauma Association Meeting(s) attended (*Required for membership*):**

Year: \_\_\_\_\_ Location: \_\_\_\_\_  
 Year: \_\_\_\_\_ Location: \_\_\_\_\_

**Abstracts Submitted to Western Trauma Association (*Required for membership*):**

Year: \_\_\_\_\_ Title: \_\_\_\_\_  
 Year: \_\_\_\_\_ Title: \_\_\_\_\_  
 Year: \_\_\_\_\_ Title: \_\_\_\_\_

**Papers Presented at Western Trauma Association:**

Year: \_\_\_\_\_ Title: \_\_\_\_\_  
 Year: \_\_\_\_\_ Title: \_\_\_\_\_

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

ENCLOSE Copy of CV and photo