NEW ENGLAND SOCIETY OF COLON AND RECTAL SURGEONS
RESIDENT MEMBERSHIP APPLICATION

NAME: _____ Date applied: _____

SPOUSE: _____

HOME ADDRESS: _____ **PHONE:** _____

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_____

PHONE: _____ **FAX:** _____

E-MAIL (home or work): _____

MED SCHOOL: _____ **YR OF GRAD:** _____

UNDERGRAD: _____ **DEGREE:** _____ **YR OF GRAD:** _____

Current ACGME approved residency program and PGY year _____

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SIGNATURE

THIS APPLICATION MUST BE SIGNED BY A SOCIETY MEMBER AND THE PROGAM DIRECTOR:

_____ MD _____ MD

PLEASE RETURN THIS FORM TO:

NESCRS
C/O TINA L. BLAIS-ARMELL
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BURLINGTON, VT 05401
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tina.blais-armell@uvmhealth.org