American College of Spine Surgery
Phone: 951-656-3816 Fax: 951-656-3890

Return this entire page with your 20___ dues to:
P. O. Box 2405, Riverside, CA 92516
(credit card users may fax this form to 951-656-3890)

Membership Application
Year: **20____**
INVOICE FOR DUES

As an organization dedicated to education and determined by the Internal Revenue Service as an organization described in section 501(c)(3), your contribution is tax deductible as provided in section 170 of the Internal Revenue Code.

PLEASE INDICATE BELOW YOUR DESIRED CATEGORY OF MEMBERSHIP:

☐ I wish to join ACSS as a Fellow *(I am a Diplomate of ABSS)* $350

☐ I wish to join ACSS as a Regular Member $300
I am Board Certified [ABNS or ABOS]

☐ I wish to join ACSS as a Corresponding Member $150

NAME____

(please print your name exactly as you wish it to appear on your Certificate)

Mailing Address____

Office Address____

Daytime Phone Fax____

Email Address____

Be sure to enclose your check to cover 20___ dues. Credit card users - see below

Payment Method: ☐ Cash ☐ Check # _________ ☐ MasterCard ☐ Visa

Credit Card #________________________________ Exp. Date_________________

NAME (exactly as it appears on Credit Card)__________________________________

Credit Card Billing Address 5-digit Zip Code __________________________________

Signature__________________________________ Date___________________

Cardholder acknowledges receipt of services in the amount of the total shown hereon and agrees to perform the obligations set forth in the Cardholder's agreement with the Issuer.

For ACSS Office Use:

Date Received: ____________________

Check #: ____________________

Posted: ______________

Date to Board: ______________ ☐ Approved ☐ Denied