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Membership Application

Please complete this application in full and return to the address below with your check made payable to CTACSPA, Inc. for \$225 for your annual dues.

Name:

Preferred Mailing Address:

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Date of Birth: Year of Graduation from Medical School:

Primary area of Specialty (please check one):

- Colon & Rectal,
- General,
- Gynecologic Oncology,
- Neurological,
- Obstetrics & Gynecology,
- Ophthalmic,
- Orthopaedic,
- Otolaryngology,
- Pediatric and Maxillofacial Surgery,
- Plastic,
- Oral and Maxillofacial Surgery,
- Thoracic,
- Vascular Surgery;
- Urology

Thank you.