APAVS
Association of Program Administrators in Vascular Surgery

# ASSOCIATION OF PROGRAM ADMINISTRATORS IN VASCULAR SURGERY (APAVS) MEMBERSHIP APPLICATION

| **MEMBERSHIP INFORMATION** | | |
|---|---|---|
| Name: | Position Title: | |
| Educational Degree(s): | Institution: | |
| Phone: | Fax: | Cell (optional): |
| Office Address: | | |
| City: | State: | ZIP Code: |
| Email Address: | Length of time in your position: | |
| **PROGRAM INFORMATION** | | |
| Current Program Name: | Integrated program:<br>0-5 ☐ 3+3 ☐ 4+2 ☐ ESP ☐ | Fellowship:<br>5+2 ☐ Other ☐ |
| Program Directors Name: | | |
| Do you manage other residency/fellowship programs: ☐ Yes ☐ No If yes what type of program(s) | | |
| How many fellows: How many residents: | | |
| Program type: Community based ☐ | University based: ☐ | Medical Center: ☐ |
| **FIELD OF EXPERTISE** | | |
| Would you be willing to speak at the annual meeting? ☐ Yes ☐ No | | |
| Topic: | | |
| **TOPICS OF INTEREST** | | |
| What topic(s) would you like to have presented at the next meeting? | | |
| **STEERING COMMITTEE** | | |
| Are you interested in becoming a member of the APAVS leadership team by becoming a Steering Committee Member? The steering committee will plan the annual meeting, maintain the website and keep the membership informed of changes.<br>☐ Yes ☐ No<br>If yes, please send an email to Mark Byrne (byrneme@upmc.edu) and an application will be sent to you. | | |
| **SIGNATURE** | | |
| I authorize the verification of the information provided on this form. (Your typed signature is sufficient) | | |
| Signature of applicant: | | Date: |

****THERE IS NO CHARGE TO JOIN THE ASSOCIATION AT THIS TIME****

**Please submit application to:**
Mark Byrne, APAVS President, byrneme@upmc.edu
Trina Smidt, APAVS Secretary, TRINA.SMIDT@CUANSCHUTZ.EDU