

**HOUSTON GYNECOLOGICAL & OBSTETRICAL SOCIETY (HGOS)
MEMBERSHIP APPLICATION**



Name:(Last, First, Middle) _____ Age: _____

Office Address: _____

City/State/Zip: _____

Office Tel No.: _____ Fax: _____

Email: _____ Date Of Birth: _____

Citizen of the United States (circle one): Y N

I submit the following data concerning my medical education and surgical training:

1. Premedical Education (University or College):

_____ From _____ to _____ Degree _____
_____ From _____ to _____ Degree _____

2. Medical Education:

_____ From _____ to _____ Degree _____
_____ From _____ to _____ Degree _____

3. Internship:

_____ From _____ to _____ Degree _____
_____ From _____ to _____ Degree _____

4. Residencies (Hospitals, Dates, and position):

5. Fellowships (Hospitals, Dates, and position):

6. Practice limited to: _____

7. Board Certification: _____ Date: _____

Signature of Applicant: _____ Date: _____

To the Houston Gynecological & Obstetrical Society:
We vouch for the character and standing of _____ M.D., and recommend his/
her election to active membership.

Sponsored by: (Signature) _____ (Print Name) _____

Endorsed by: (Signature) _____ (Print Name) _____

Return completed application with \$210 membership fee to lisa.hgos@gmail.com. New graduates are free for their first 6 months and pay a discounted fee of \$100 for their first full calendar year.