

SOUTHERN EPILEPSY & EEG SOCIETY

Application for Membership

Please type or print

Annual Membership Fee: \$50.00

Name: _____ Degree: _____
(Last) (First) (Middle)

Affiliation: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Present position/Title: _____

Undergraduate Training:

<u>University</u>	<u>Degree</u>	<u>Dates</u>
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Post Graduate Training:

<u>University</u>	<u>Degree</u>	<u>Dates</u>
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Residency and Epilepsy/EEG Training:

<u>Institution</u>	<u>Director</u>	<u>Dates</u>	<u>% of time</u>
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Hospital and/or Teaching Affiliations:

Specialty Board Certification: _____ Date: _____

Signature: _____ Date: _____

Date received by the secretary: _____

Action of members of council: Approved: _____ Disapproved _____ Date: _____

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