

Southern Epilepsy & EEG Society

Application for Membership

Please type or print

Annual Membership Fee: \$50.00

Name: _____ Degree: _____

Affiliation: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Present position/title: _____

Undergraduate Training:

<u>University</u>	<u>Degree</u>	<u>Dates</u>
_____	_____	_____

Post Graduate Training:

<u>University</u>	<u>Degree</u>	<u>Dates</u>
_____	_____	_____

Residency and Epilepsy/EEG Training:

<u>Institution</u>	<u>Director</u>	<u>Dates</u>	<u>% of time</u>
_____	_____	_____	_____

Hospital and/or Teaching Affiliations:

Specialty Board Certifications:

- American Board of Psychiatry and Neurology–Neurology Date: _____
- American Board of Psychiatry and Neurology–Special Qualifications in Child Neurology Date: _____
- American Board of Psychiatry and Neurology–Special Qualifications in Clinical Neurophysiology Date: _____
- American Board of Psychiatry and Neurology–Special Qualifications in Epilepsy Date: _____
- American Board of Psychiatry and Neurology–Special Qualifications in _____ Date: _____
- American Board of Clinical Neurophysiology Date: _____
- Other board: _____ Date: _____

Signature: _____ Date: _____

Date received by secretary: _____
Action of members of council: Approved ____ Disapproved ____ Date: _____