Dear Colleague:

Thank you for your interest in becoming a member of the New England Dermatological Society (NEDS). To begin the application process, please submit an application which is available as a hard copy (attached) or on our website www.nederm.org, along with a $225 application fee that will cover your dues for the first year of membership. To complete your application, you will also need to submit a letter of reference from Active NEDS member (template attached).

The New England Dermatological Society offers a 50% discount on the first year’s membership dues for any person who applies within one year of completing residency or fellowship training. The Society also offers a $50 rebate on membership dues to any member who refers a new member to the Society.

Your application will be reviewed at the next scheduled council meeting when all necessary information is received.

If you should have any questions please feel free to contact our Administrator by telephone at (781) 434-7731 or e-mail at neds@mms.org.

Jennifer Huang, MD
Secretary, New England Dermatological Society
NEDS Membership Application

Full Name: ____________________________________________

Rewferred by: __________________________________________

Home Address: Office Address:
_____________________________________________________
_____________________________________________________
_____________________________________________________

Office Phone: __________________________
Office Fax: __________________________
Email address: _______________________

Date of Birth: __ / __ / __
Place of Birth: __ / __ / __

Citizen of U.S.A.? _____ If no, citizen of ________________

How long have you practiced at the present address? _____________

I hereby apply for the following membership category (check one):

___ Active Board certified by the American Board of Dermatology
___ Associate Completed 3 years of training in dermatology but not board certified
___ Affiliate Non-dermatologists with dermatology related specialty (i.e. researcher, pathology-trained dermatopathologist)
___ Adjunct Nurse practitioners and physician assistants who work under the supervision of an active member

If applying for Active membership, year when board-certified in dermatology: ____

Please list other board-certifications:
_________________________________________Year: ______
_________________________________________Year: ______
_________________________________________Year: ______
_________________________________________Year: ______
If applying for Adjunct membership, please fill out this section:

Check one:  Nurse Practitioner: _____  Physician Assistant: _____

Please name your supervising Dermatologist: ____________________________

Length of time working with the above Dermatologist: ______________

What portion of your practice is devoted to seeing dermatology patients? ________%  

If not 100%, how is your other time spent?

____________________________________________________________________

Training and Education (complete all that apply) OR Attach your CV

1. Undergraduate:
   Degree: _______  Year completed: _______
   School: ___________________________
   Location: _________________________

2. Graduate:
   Degree: _______  Year completed: _______
   School: ___________________________
   Location: _________________________

3. Additional Graduate:
   Degree: _______
   School: ___________________________
   Location: _________________________

4. Internship and Residency:
   Specialty: ________________  Year completed: _______
   Location: _________________________

   Specialty: ________________  Year completed: _______
   Location: _________________________

   Specialty: ________________  Year completed: _______
   Location: _________________________

Phone: (781) 434-7731  Fax: (781) 464-4896
5. Fellowship training:
   Specialty: __________________ Year completed: ______
   Location: ________________________________
   Specialty: __________________ Year completed: ______
   Location: ________________________________

Present hospital positions held (do not list courtesy affiliations):
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Present teaching positions held:
__________________________________________________________________________
__________________________________________________________________________

Medical Society memberships:
__________________________________________________________________________
__________________________________________________________________________

Areas of interest / expertise:
__________________________________________________________________________

Publications:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

List one Active member who will send letters of endorsement on your behalf:
1. ________________________________
Please return your application, payment and letter of endorsement to the following address:

NEDS Administrator
New England Dermatological Society
P.O. Box 549127
Waltham, MA 02454-9127
neds@mms.org
781-464-4896 Fax

Application Fee: The $225 application fee is applied toward your first year of membership dues. If not paying by credit card, please forward a check payable to “New England Dermatological Society” to the address above.

Signature: ______________________________________________________

Date: ____________________________________________________________________________
TO: NEDS Administrator  
New England Dermatological Society  
PO Box 549127  
Waltham, MA 02454-9127  
neds@mms.org  
781-464-4896 Fax

Dear Administrator:

I would like to recommend ____________________________ Name & Suffix for membership in the New England Dermatological Society. As a well-trained and competent dermatologist (or substitute with one of the following as needed: dermatologist, researcher, pathology-trained dermatopathologist, nurse practitioner or physician assistant) s/he would be an asset to our society.

Sincerely,

____________________________
Signature

____________________________
Printed Name