

ESLD - European Society for Laser Dermatology

DEPARTMENT OF MEMBER SERVICES

PLEASE TYPE AND LEAVE NO BLANKS ON APPLICATION

(* EMAIL IS MANDATORY AS IT WILL BE OUR MEANS OF COMMUNICATION)

DATE

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I hereby apply for membership as: **ORDINARY MEMBER (DERMATOLOGIST ONLY)**
 ASSOCIATE MEMBER FELLOW MEMBER

NAME _____ **TITLE** _____
Last First Middle Initial

OFFICE
ADDRESS _____
Number & Street City & Country Zip

Telephone Number (including Country & City Code) Fax Number

Email* _____

HOME
ADDRESS _____
Number & Street City & Country Zip

Telephone Number (including Country & City Code) Fax Number

Email* _____

MAIL SHOULD BE DIRECTED TO: OFFICE HOME _____

EDUCATION: INSTITUTION, LOCATION AND INCLUSIVE DATES

GRADUATE SCHOOL _____
Year Completed Degree

POST GRADUATE (Residency) _____
Year Completed

OTHER SPECIALTY TRAINING _____
Institution & Location Num. of years Year Completed

SPECIALTIES _____
University Country Year Completed

University Country Year Completed

CERTIFICATION: EUROPEAN BOARD OF: _____
Country Year

AMERICAN BOARD OF: _____
Country Year

EQUIVALENT BOARDS: _____
Country Year

Are you currently practicing LASER DERMATOLOGY within your practice full time? Yes No

If yes, indicate the type of practice (after completion of residency training):

Solo Clinic Group Other

INSTITUTION OR UNIVERSITY AFFILIATION: _____

ACADEMIC RANK OR POSITION: _____

MEMBER IN GOOD STANDING OF: _____

ELECTIVE OFFICE APPOINTMENTS:

(list any office or committee appointments you hold or have held)

Please, check the appropriate square(s) indicating the procedures that you routinely perform. Specify also your experience (in years).

BASIC ABLATIVE LASER SURGERY

incision & vaporization yr. _____

ADVANCED ABLATIVE LASER SURGERY

skin resurfacing yr. _____
 blepharoplasty yr. _____
 Er:YAG yr. _____

VASCULAR LESIONS TREATMENT

pulsed dye (PDL) yr. _____
 KTP yr. _____
 1064 NM YAG yr. _____
 IPLS yr. _____

TATTOO LASER TREATMENT

QS Nd:YAG yr. _____
 QS ruby yr. _____
 QS alexandrite yr. _____

VARIA

Photodynamic therapy yr. _____
 Radiofrequency: yr. _____
 other: yr. _____

PIGMENTED LESIONS TREATMENT

QS ruby yr. _____
 QS alexandrite yr. _____
 QS Nd:YAG yr. _____
 IPLS: yr. _____

HAIR REMOVAL: yr. _____

PHOTOREJUVENATION: yr. _____

SKIN TIGHTENING – CELLULITIS – FAT REMOVAL: yr. _____

List one name of **two** active members of ESLD from whom the Committee will receive a letter of endorsement. One of them might be your *National Coordinator*.

Please request your endorser to forward his/her letter as soon as possible.

1. _____
Name

Address

City / Country / Zip

2. _____
Name

Address

City / Country / Zip

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AS RECORDED.

SIGNATURE

DATE

**Return this form to:
ESLD Secretarial Office
Attn. Mrs. Tanja Helms
Syker Strasse 40-42
27211 Bassum
GERMANY
Phone +49 (0) 42 41 / 93 32 49
Fax +49 (0) 42 41 / 93 32 40
Email office@esld.org
Website www.esld.org**