

Application For Membership

Last Name: _____ First Name: _____ MI: _____

Degree or Title: _____

Date of Birth: _____ Race (optional): _____

Mailing Address: _____

City: _____ State: _____

Zip Code: _____

Telephone: _____ Fax: _____

E-Mail: _____

Education (College, Graduate, Professional, Other): _____

Current Affiliation: _____

Title: _____

Board Certification: _____

Employer: _____

Majority of time spent (private practice, academics, industry, etc.): _____

Area of interest within Dermatology: _____

Membership fee: \$50.00

Please Send to: The Skin of Color Society
c/o Patricia Conn
Department of Dermatology
University of Texas
Southwestern Medical Center at Dallas
5323 Harry Hines Blvd. MC-9190
Dallas, TX 75390
Ph: 214.648.5770
Fx: 214.648.5777