



S·S·U
STATE SURGEONS UNIT



RENEWAL APPLICATION		
Last:	First:	MI:
PLEASE <u>ONLY</u> COMPLETE THE FOLLOWING IF ANY INFORMATION HAS CHANGED		
Mailing Address:		
City:	State:	ZIP Code:
Primary Number: () -	Primary Email:	
Name of Practice:		
Practice's Website:		
Office Address:		
Office Number: () -	Office Fax: () -	Mobile: () -
Referred By:		
VEHICLE INFORMATION		
If your vehicle(s) has changed, please provide the following information to register your parking placard:		
Vehicle 1 - Year:	Make:	Model:
License Plate:	State:	
Vehicle 2 - Year:	Make:	Model:
License Plate:	State:	
FOR OFFICE USE ONLY:		
Date Renewal Received:		
Current Shield & ID Card Number:		
New Placard Number:		
Date Approved:		

AGREEMENT

I hereby apply to become a participating doctor and Member of the State Surgeons Unit.

Becoming a member of the State Surgeons Unit does not give you any authority as a law enforcement officer. The ID card, shield and placard will not be used to violate or abuse any municipal, vehicle and traffic laws, or penal laws. It is up to the discretion of the State Surgeons Unit to allow member into the organization and to revoke membership if necessary. All materials (ID card, shield, placard) received from the organization are property of the organization and must be returned upon request.

In the event that I choose to terminate this membership, I agree to notify the SSU in writing at least thirty (30) days in advance of the effective date of termination. I understand that the State Surgeons Unit reserves the right to terminate my membership in the organization. I understand that if my membership is discontinued for any reason, I will return all materials (ID card, shield, placard) pertaining to the organization.

Certification: I certify that the statements and information set forth on this document are true and correct. I make these statements, provide this information and sign my name with the knowledge that willfully making and signing a document containing false or incorrect matters or willfully issuing a false or fraudulent document is punishable under penalty of law. My signature below indicates my agreement to and acceptance of the terms and conditions of membership as outlined by the State Surgeons Unit and set forth in this application.

Signature: _____

Date: _____