

AAOA Membership Application

Name _____	Degree _____	Date _____
Home Number _____	Cell Phone _____	
Office Practice Name _____	Office Practice Website _____	
Office Address _____	City State Zip _____	
Office Number _____	Office Fax _____	

E-mail Address Required (Please provide a unique, preferable personal email address)

I certify that the information presented on this application is true, correct and complete. I understand that if any information I have submitted on or within this application is untrue, incorrect or incomplete, I may be subject to discipline by the AAOA, which discipline may include being expelled from the organization.

I Wish to Enroll As:

<input type="checkbox"/> ASSOCIATE <ul style="list-style-type: none"> \$435 application fee Proof of successful completion of residency Copy of ABOto Board certificate/proof of eligibility 	<input type="checkbox"/> RESIDENT <ul style="list-style-type: none"> \$45 one-time Resident Dues Letter of recommendation from Department Chair on letterhead Estimated completion date Resident membership is free with active membership of Program Chair or Training Program Director 	<input type="checkbox"/> ALLIED HEALTH <ul style="list-style-type: none"> \$205 application fee Letter of recommendation from the AAOA member physician for whom the Allied Health applicant works
<input type="checkbox"/> ACADEMIC ASSOCIATE <i>(full-time faculty)</i> <ul style="list-style-type: none"> \$435 application fee Letter from Department Chair confirming full-time faculty status on letterhead Proof of successful completion of residency Copy of ABOto Board certificate/proof of eligibility 	<input type="checkbox"/> MILITARY ASSOCIATE <ul style="list-style-type: none"> \$435 application fee Letter from the Superior Officer confirming full-time military status on letterhead Proof of successful completion of residency Copy of ABOto Board certificate/proof of eligibility 	<input type="checkbox"/> INTERNATIONAL MEMBER <ul style="list-style-type: none"> \$435 application fee (payable in US dollars) Proof of recognition as a practicing otolaryngologist within current country Proof of maintaining an active otolaryngology practice

Medical School _____ Year Completed _____

OTO Residency _____ Year Completed/Projected _____

Other Residency _____ Year Completed _____

Board Certification _____ Year Completed _____

Practice Type: Private Employed Academic

Practice Size: # of Physicians _____ # of Staff _____

Medical Societies _____

SCOPE OF PRACTICE (define percentage in each)

Allergy _____	Rhinology _____
Otology _____	Laryngology _____
Head & Neck _____	Facial Plastics _____
Other _____	

Please mail completed application and your check payable to:

AAOA Inc.
Attn: Membership
11130 Sunrise Valley Drive | Suite 100
Reston, Virginia 20191

or fax completed application to 202.955.5016 and call the AAOA office at 202.955.5010 on the next business day to pay by credit card

