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:

❑ **ASSOCIATE**

- *$435 application fee*
- *Proof of successful completion of residency*
- *Copy of ABOto Board certificate/ proof of eligibility*

❑ **RESIDENT**

- *$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*

❑ **ALLIED HEALTH**

- *$205 application fee*
- *Letter of recommendation from the AAOA member physician for whom the Allied Health applicant works*

❑ **ACADEMIC ASSOCIATE** *(full–time faculty)*

- *$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*

❑ **MILITARY ASSOCIATE**

- *$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*

❑ **INTERNATIONAL MEMBER**

- *$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

Completed applications can also be scanned and emailed to bwokas@aaoallergy.org or faxed to 202.955.5016. Call the AAOA office at 202.955.5010 on the next business day to pay by credit card. Contact bwokas@aaoallergy.org with any questions.