

AAOA Membership Application

First Name _____	Last Name _____	Degree _____	DOB / / _____
E-mail Address Required (Please provide a unique, preferably personal email address) _____		Personal Phone _____	
Office Practice Name _____		Office Phone _____	
Office Address _____		City State Zip _____	
Optional: Ethnicity/Race: _____		Gender: M / F / Other _____	
<p><i>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></p>			
Signature _____		Application Date _____	

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"/> ACADEMIC ASSOCIATE (full-time faculty) <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"/> 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
<input type="checkbox"/> ADVANCED PRACTITIONER (NP/PA) <ul style="list-style-type: none"> \$205 application fee Letter of recommendation from the AAOA member physician for whom the applicant works 	<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"/> 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 		

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 (check major practice areas)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Rhinology |
| <input type="checkbox"/> Otology | <input type="checkbox"/> Laryngology |
| <input type="checkbox"/> Head & Neck | <input type="checkbox"/> Facial Plastics |
| <input type="checkbox"/> 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@aaoaallergy.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@aaoaallergy.org with any questions.

