THE AMERICAN ACADEMY OF NEUROLOGICAL AND ORTHOPAEDIC SURGEONS

APPLICATION FOR MEMBERSHIP

American Academy of Neurological and Orthopaedic Surgeons
1516 N. Lake Shore Drive
Chicago, Illinois 60610 U.S.A.
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Fax: 312-787-9289
Email: aanos@aanos.org
Website: www.aanos.org

For AANOS use only

Rcvd: _____ Approved: _____

Credentialling Committee
Approved _____ Not Approved ____
Signature _____

Membership Committee
Approved _____ Not Approved ____
Signature _____

Membership Dues & Application Fees

~ All fees and dues must be enclosed with application for processing ~

☐ **Application Processing Fee $ 150.00 one time fee only.**

☐ **New Active Member Dues $ 300.00 first year ~ after such time $600.00 per year.**
For physicians who are practicing and are fully trained in neurology, neurosurgery, orthopaedics and all physicians in other specialties practicing in fields related to neurology and orthopaedics. New members will enjoy all benefits of membership.
One check in the amount of $450.00US can be remitted for required fees.

Contact Information: *Please clip a passport photo of yourself to the application.*

~ Please Print ~

NAME:_____ Degree: _____
(Last) (First) (M)

BUS. ADDRESS:_____
(Address) (City) (State) (Zip)

BUS. PHONE: _____ BUS. FAX: _____ EMAIL: _____

*HOME ADDRESS:_____
(Address) (City) (State) (Zip)

*HOME PHONE:_____ *HOME FAX:_____ *DATE OF BIRTH:_____

PRIMARY SPECIALTY:_____ *SECONDARY SPECIALTY:_____

*CURRENT AMERICAN MEDICAL ASSOCIATION MEMBER: YES___ NO:

Contact information maybe published on the AANOS Website, JONOMS and Membership Directory.
Please indicate below your preference for published information.
(* Information will not be published)

○ **Yes, You may publish my business information**
○ **No, I do not wish to have my business information published**

Over →

Medical Education: *Attach All Certificates: Medical School Graduation and Training Certificates.*

MEDICAL SCHOOL:_____
(Name of School) *(City, State/Country)* *(Dates: From-To MM/YY)*

INTERNSHIP:_____
(Hospital) *(Complete Address)* *(Dates: From-To MM/YY)*

GENERAL SURGERY:_____
(Hospital) *(Complete Address)* *(Dates: From-To MM/YY)*

Residency: *Attach All Residency Certificates.*

1st Year:_____
(Hospital) *(Complete Address)* *(Dates: From-To MM/YY)*

2nd Year:_____
(Hospital) *(Complete Address)* *(Dates: From-To MM/YY)*

3rd Year:_____
(Hospital) *(Complete Address)* *(Dates: From-To MM/YY)*

4th Year:_____
(Hospital) *(Complete Address)* *(Dates: From-To MM/YY)*

Please Answer the Following: *If the answer to any of the below questions is Yes, please explain on your business letterhead and attach to this application. *Attach a Copy of All-Medical License(s), DEA License and Pharmacy License(s).*

1. Have you ever had your medical license, pharmacy, or DEA license reclassified, suspended, restricted or revoked?	○ Yes *	○ No
2. Have you had a physical, emotional, alcohol/substance abuse problem that may impair your judgement or performance?	○ Yes*	○ No
3. Have you been subject to a disciplinary action by a medical society, hospital, or board?	○ Yes*	○ No
4. Have your privileges, medical or surgical, been revoked or curtailed by any hospital?	○ Yes*	○ No

Membership Participation:

I am willing to present abstracts for the Annual Scientific Meetings.	○ Yes	○ No
I am willing to submit articles for Publication in the Journal of Neurological & Orthopaedic Medicine and Surgery (JONOMS).	○ Yes	○ No
I agree to attend one Annual Scientific Meeting at least every three years in order to maintain my membership status.	○ Yes	○ No

To complete this application, please enclose two letters of recommendation from colleagues in your specialty. This letter must be on their letterhead with contact information and must include dates of practice observation and signature.

~ Enclosure & Attachments Checklist ~

Referred by:

◇ **A**pplication Processing Fee $ 150.00	◇ **N**ew Member Dues $ 300.00	◇ **P**assport Photo
◇ **M**edical School Certificate	◇ **A**ll Training & Residency Certificates	◇ **2** Colleague Recommendation Letters
◇ **C**urrent Curriculum Vitae (Resume)	◇ **A**ll State Medical License(s)	◇ **D**EA & Pharmacy License(s)

I hereby certify that under penalty of perjury by law, the aforementioned are all true and there is no ill intent or bad faith involved in my application for membership. I also understand that any falsifications of reports, misrepresentations of material, significant omissions, dishonesty, forgery, and unethical practices will automatically render my application null and void. I moreover agree to comply with the By-Laws of the Academy and their rules and regulations. I agree to indemnify, release, and hold harmless the American Academy of Neurological and Orthopaedic Surgeons and its agents of any torts by reason of their acts or omissions regarding my application. I authorize full investigation of my application. My signature below is an authorization to anyone to release information you may request on me to help the Academy make an accurate assessment/evaluation of me.

_____
(Signature) (Date)