AMERICAN ACADEMY OF NEUROLOGICAL AND ORTHOPAEDIC SURGEONS
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APPLICATION FOR MEMBERSHIP

Contact Information:

Please Print

FULL LEGAL NAME: _____ Degree: _____

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

BUS. PHONE: _____ BUS. FAX: _____

PRIMARY EMAIL: _____ SECONDARY EMAIL: _____

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

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

PRIMARY SPECIALTY: _____ *SECONDARY SPECIALTY: _____

* Your business contact information may be published in a searchable online directory. Home or personal information will never be published. If you do not wish your information to be published, please check the box below. Note that the searchable directory will be used by hospital and insurance company credentialing departments to verify your membership and if pertinent your certification status.

☐ **I do not wish to have my business information published**

Please answer the following questions: ***If the answer to any of the below questions is YES, you must provide a detailed explanation on your business letterhead and attach to this application.**

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 Have your privileges, medical or surgical, been revoked or curtailed by any hospital?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

Required Documentation:

***Important**: Submission of all of the documents on the following checklist is required or application will not be processed.*

___ **Current Curriculum Vitae** (Must include Medical School name and location, as well as any post graduate training programs you completed – Internship, Residency, Fellowship, etc.)
___ **Copy of Medical School Diploma**
___ **Copies of all Training & Residency Certificates**
___ **Two (2) Letters of Recommendation** (Must be from colleagues who are of the same specialty. One should preferably be from the Head of the Department at a hospital where you have or have had privileges. Letters must be on letterhead which includes contact information, dates of practice observation and signature. Letters must come directly from referee.)
___ **Copies of all State Medical License(s)**
___ **Copies of DEA & Pharmacy License(s)**

If you were referred to the Academy by a current member, please provide their name. _____

Fees:

All fees, payable in US dollars, must be paid prior to application being processed. Fees include the following: a **$150.00** Application Processing Fee (one-time fee) and a **$300.00** New Active Member Dues payment for your first year (*after such time annual dues are $600.00 per year*). Membership is open to all surgeons (MD or DO) who are actively practicing neurosurgery or orthopaedic surgery. Physicians and surgeons in other specialties who have an interest in the Academy and its mission may also join as full active members and will enjoy all benefits of membership. Residents in training and Allied Health professionals are also welcome to join as Associate Members at discounted membership rates. Contact the Academy for more information or visit the website for more details or to obtain the appropriate application form.

Total payment required with application is $450.00 and can be remitted as follows:

☐ Bank Check (US bank in US$) ☐ Visa/ MasterCard ☐ American Express

If paying by credit card, please provide the following information:

Name on card _____

Card number _____

Expiration date _____ Security code _____ Billing zip code _____

FOR AANOS USE ONLY

Received: _____
Out for review: _____
Approved: _____

Certification and Signature:

I hereby certify that under penalty of law for perjury, the information I have provided in this application and supporting documents is all true and there is no ill intent or bad faith involved in my application for membership. I also understand that any falsification of reports, misrepresentation of material, significant omissions, dishonesty, forgery, and unethical practices will automatically render my application null and void. I moreover agree to comply with the Bylaws 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