AMERICAN ACADEMY OF NEUROLOGICAL AND ORTHOPAEDIC SURGEONS
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APPLICATION FOR ASSOCIATE MEMBERSHIP

NOT APPROPRIATE FOR PHYSICIANS (MD OR DO)

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 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 professional society, hospital, or board?	○ Yes* ○ No
4. Have your privileges been revoked or curtailed by any hospital?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 all School names and locations (under-graduate and beyond), as well as any post graduate training programs you completed)

___ **Copy of Education Diplomas**

___ **Copies of all Training Certificates**

___ **Letter of Recommendation** (Must be from a physician colleague with whom you work, preferably a member of the Academy. The letter must be on letterhead including contact information and must include dates of practice observation. and signature.)

___ **Copies of all State Medical 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 **$100.00** Application Processing Fee (one-time fee) and a **$150.00** New Active Associate Member Dues payment for your first year (*after such time annual dues are $300.00 per year*). Associate Membership is open to Surgical Residents in Training, Physician Assistants, Nurse Practitioners, Physical Therapists, and other non-physicians (MD/DO) who work in the medical field.

Total payment required with application is $250.00 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

The American Academy of Neurological and Orthopaedic Surgeons does not discriminate on the basis of race, color, national origin, sex, age, handicap or religion. The Academy adheres to all laws including, but not limited to the Civil Rights Act of 1964 as well as Title IX of the Education Amendments of 1972.