

# 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:

<input type="checkbox"/> <b>ASSOCIATE</b> <ul style="list-style-type: none"> <li>\$375 application fee</li> <li>Proof of successful completion of residency</li> <li>Copy of ABOto Board certificate/proof of eligibility</li> <li>Two (2) letters of recommendation from AAOA members (preferably Fellows)</li> </ul>	<input type="checkbox"/> <b>RESIDENT</b> <ul style="list-style-type: none"> <li>\$45 one-time Resident Dues</li> <li>Letter of recommendation from Department Chair on letterhead</li> <li>Estimated completion date</li> <li>Resident membership is free with active membership of Program Chair or Training Program Director</li> </ul>	<input type="checkbox"/> <b>ALLIED HEALTH</b> <ul style="list-style-type: none"> <li>\$175 application fee</li> <li>Letter of recommendation from the AAOA member physician for whom the Allied Health applicant works</li> </ul>
<input type="checkbox"/> <b>ACADEMIC ASSOCIATE</b> <i>(full-time faculty)</i> <ul style="list-style-type: none"> <li>\$375 application fee</li> <li>Letter from Department Chair confirming full-time faculty status on letterhead</li> <li>Proof of successful completion of residency</li> <li>Copy of ABOto Board certificate/proof of eligibility</li> </ul>	<input type="checkbox"/> <b>MILITARY ASSOCIATE</b> <ul style="list-style-type: none"> <li>\$375 application fee</li> <li>Letter from the Superior Officer confirming full-time military status on letterhead</li> <li>Proof of successful completion of residency</li> <li>Copy of ABOto Board certificate/proof of eligibility</li> </ul>	<input type="checkbox"/> <b>INTERNATIONAL MEMBER</b> <ul style="list-style-type: none"> <li>\$375 application fee (payable in US dollars)</li> <li>Proof of recognition as a practicing otolaryngologist within current country</li> <li>Proof of maintaining an active otolaryngology practice</li> </ul>

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**

or fax completed application to 202.955.5016 and call the AAOA office at 202.955.5010 on the next business day to pay by credit card

