AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY®

2023 Membership Application

WHAT IS YOUR PRIMARY SUBSPECIALTY? (SELECT ONLY ONE):

- ◯ Allergy
- ◯ Endocrine Surgery
- ◯ Facial Plastic & Reconstructive Surgery
- ◯ General Otolaryngology
- ◯ Head and Neck Surgery
- ◯ Laryngology
- ◯ Neurotology
- ◯ Otology/Audiology
- ◯ Pediatric Otolaryngology
- ◯ Rhinology
- ◯ Sleep Medicine

SECONDARY SUBSPECIALTY (FROM THE LIST ABOVE, PLEASE SELECT ONLY ONE):

WHAT IS YOUR PRIMARY PRACTICE TYPE?

- ◯ Clinical Non-Physician
- ◯ Group Multi-Specialty - Primary Care & Specialty Care
- ◯ Group Multi-Specialty - Specialty Care Only
- ◯ Group Single Specialty - Other
- ◯ Group Single Specialty - Otolaryngology
- ◯ Non-Clinical Organization
- ◯ Not in Active Practice
- ◯ Research
- ◯ Solo Private Practice

SECONDARY PRACTICE TYPE (FROM THE LIST ABOVE, PLEASE SELECT ONLY ONE):

WOULD YOU CONSIDER YOUR SETTING? (SELECT ONLY ONE):

- ◯ Academic Practice
- ◯ Ambulatory Surgery Center
- ◯ Government (VA)
- ◯ Hospital or Health System (Employed)
- ◯ Off Campus Hospital Department (Offsite, Owned by Hospital)
- ◯ Private Practice
- ◯ Staff Model HMO

BIRTH YEAR: _____

ETHNICITY:

- ◯ *African American*
- ◯ *American Indian*
- ◯ *Asian*
- ◯ *Caucasian*
- ◯ *Hispanic/Latino*
- ◯ *Other*_____

GENDER:

LICENSING AND CERTIFICATION

Licensed to Practice in: ◯ *United States* ◯ *International*

List State(s)/Countries:

PERSONAL DATA

Last Name/Surname/Family Name | *First/Given Name* | *Middle Initial*

PROFESSIONAL MAILING ADDRESS (Listed in the Online Membership Directory, if no professional address is provided, only your name will be listed in the directory) Is this your Preferred Billing Address? ◯ Yes ◯ No

Institution/Company Name

Department

Street Address

Suite/Room/Apartment

City | *State/Province*

Country | *ZIP/Postal Code*

Phone (with Area or Country Code)

Fax (with Area or Country Code)

Email Address

Web Address

PREFERRED MAILING ADDRESS Is this your Preferred Billing Address? ◯ Yes ◯ No

Street Address

Suite/Room/Apartment

City | *State/Province*

Country | *ZIP/Postal Code*

Home Phone (with Area or Country Code)

Mobile (with Area or Country Code)

Email Address

MEDICAL TRAINING

Medical School (Required)

Name of School or Program

City and State/Province | *Completion Year* | *Degree(s)* *(e.g., MD, DO, MBBS, FRCS)*

Residency Training (Required)

Name of School or Program

City and State/Province | *Completion Year*

Fellowship Training (if Applicable)

Name of School or Program

Type of Fellowship (e.g., Laser Application, Rhinology, Clinical Research)

City and State/Province | *Completion Year*

Postgraduate Degrees Other than Formal Medical Degree (if Applicable)

Name of School or Program

Type of Study | *Degree(s) (e.g., MD, MBBS, FRCS)*

STATEMENT OF ENDORSEMENT

Applicants must obtain ***two (2)*** endorsement signature from an active AAO-HNS member or an officer of their national society. ***(Can be provided at a later date.)*** ***Practice Administrators do not have to obtain endorsements, but do have to provide the names of current AAO-HNSF member physicians in their practice.***

APPLICANT NAME

Please Print Your Full Name

By signing the endorsement for this applicant for membership in the American Academy of Otolaryngology—Head and Neck Surgery, I certify that I have personal knowledge of the applicant and I am familiar with the applicant's professional competence and conduct.

ENDORSER 1:

Print Full Name

AAO-HNS ID#

Signature

Name of National Society

ENDORSER 2:

Print Full Name

AAO-HNS ID#

Signature

Name of National Society

MEMBERSHIP CATEGORIES

RESIDENT/MEMBER-IN-TRAINING/FELLOW-IN-TRAINING/MEDICAL STUDENT

MD or DO or equivalent medical degree and/or a valid and unrestricted license to practice medicine, or a full time medical student. Residents must be enrolled in a full-time training program. Members-in-Training must be enrolled in a fellowship or postgraduate training program and cannot be board-certified. Fellows-in-Training must be enrolled in a fellowship or postgraduate training program and certified by a specialty board. Students must be enrolled in a full-time medical school program or an undergraduate pre-med program.

INTERNATIONAL PHYSICIAN AND FELLOW

MD or DO or equivalent with a valid and unrestricted license to practice medicine in a country other than the U.S. or Canada. Fellows are certified by a medical specialty board.

-Special pricing for members residing in World Bank-designated lower middle income and low income countries.

AFFILIATE

An individual supportive of otolaryngology—head and neck surgery, but not eligible for any other type of membership category.

PHYSICIAN AND FELLOW

MD or DO with a valid and unrestricted license to practice medicine in the U.S. or Canada. Fellows are certified by a specialty board. Scientific Fellows have a PhD or equivalent in a field associated with otolaryngology.

ASSOCIATE

MD, DMD, or DDS and engaged in or allied to otolaryngology—head and neck surgery. Associates are not eligible for any other type of membership category.

PRACTICE ADMINISTRATOR

An individual currently working as an administrator for an otolaryngology practice

PHYSICIAN AND FELLOW	INTERNATIONAL PHYSICIAN AND FELLOW	PRACTICE ADMINISTRATORS*	AFFILIATE	RESIDENT MEMBER-IN-TRAINING AND FELLOW-IN-TRAINING	INTERNATIONAL RESIDENT MEMBER-IN-TRAINING AND FELLOW-IN-TRAINING	STUDENT (MEDICAL OR UNDERGRADUATE)
$1,090 Physician/Fellow $840 Military/Government $120 Retired Physician/Fellow $675 Scientific (MD, PhD) $360 First Year Practicing $725 Second Year Practicing	$625 Physician/Fellow $208* First Year Practicing $416* Second Year Practicing $312 Lower Middle Income $156 Low Income	$135 (ASCENT Members) $185 (Non-ASCENT Members)	$305	$120	$105 International $52 Lower Middle Income $26 Low Income	$30

** International pricing based on World Bank country classification.*
Duplicate payments will be credited to the next dues cycle unless a refund is requested.

AMOUNT DUE: ◯ *Check* ◯ *VISA* ◯ *MasterCard* ◯ *American Express* ◯ *Wire Transfer*

Credit Card Number

Signature

Expiration Date (MM/YY)

Security Code

Name on Credit Card

RETURN APPLICATION WITH PAYMENT TO:

American Academy of Otolaryngology –Head and Neck Surgery

ATTN: Member Services

1650 Diagonal Road
Alexandria, VA 22314-2857, U.S.A.

Make checks payable to AAO-HNS

Email: memberservices@entnet.org

WIRE TRANSFERS ONLY:

To wire transfer funds to the AAO-HNS, send to:

Truist Bank
1445 New York Ave, NW
Washington, DC 20005
Account Number: 1000208996974
ABA Routing Number: 061000104
SWIFT/BIC CODE: BRBTUS33
(International Wire Only)

Please include your full name on all correspondence.

AAO-HNS ETHICS AND PRIVACY STATEMENT

I certify that the above information is true and correct. I understand that any material false statement or misrepresentation (including omission of fact) on this application or on any document used to secure membership can be grounds for rejection of my application or, if I am granted membership, grounds for termination of my membership in the American Academy of Otolaryngology-Head and Neck Surgery. I understand if accepted, I agree to abide by the AAO-HNS bylaws, member-related policies, and the Code of Ethics and related appendices. I understand the AAO-HNS may periodically share my mailing address with third parties for single-use mailings for products and services that I may be interested in. AAO-HNS will NOT provide Email addresses, telephone numbers or any other types of personally identifiable information to third parties.

Signature of Applicant **(REQUIRED)**

Date