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:

❑ ASSOCIATE

- *$375 application fee*
- *Proof of successful completion of residency*
- *Copy of ABOto Board certificate/ proof of eligibility*
- *Two (2) letters of recommendation from AAOA members (preferably Fellows)*

❑ RESIDENT

- *$45 one-time Resident Dues*
- *Letter of recommendation from Training Program Director or Department Chair on letterhead*
- *Estimated completion date*
- *Resident membership is free with active membership of Program Chair or Training Program Director*

❑ ALLIED HEALTH

- *$175 application fee*
- *Letter of recommendation from the AAOA member physician for whom the Allied Health applicant works*

❑ INTERNATIONAL MEMBER

- *$375 application fee (payable in US dollars)*
- *Proof of recognition as a practicing otolaryngologist within current country*
- *Proof of maintaining an active otolaryngology practice*

❑ ACADEMIC ASSOCIATE

(full–time faculty)

- *$375 application fee*
- *Letter from Department Chair confirming full-time faculty status on letterhead*
- *Proof of successful completion of residency*
- *Copy of ABOto Board certificate/proof of eligibility*

❑ MILITARY ASSOCIATE

- *$375 application fee*
- *Letter from the Superior Officer confirming full-time military status on letterhead*
- *Proof of successful completion of residency*
- *Copy of ABOto Board certificate/proof of eligibility*

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

AMERICAN ACADEMY OF OTOLARYNGIC ALLERGY