

# THE AMERICAN ACADEMY OF NEUROLOGICAL AND ORTHOPAEDIC SURGEONS

## APPLICATION FOR MEMBERSHIP

American Academy of  
Neurological and Orthopaedic  
Surgeons  
10 Cascade Creek Lane  
Las Vegas, Nevada 89113 U.S.A.  
Phone: 702-388-7390  
Fax: 702-871-4728  
Email: [aanos@aanos.org](mailto:aanos@aanos.org)

For AANOS use only

Rcvd: \_\_\_\_\_ Approved: \_\_\_\_\_

### Credentialling Committee

Approved \_\_\_\_\_ Not Approved \_\_\_\_\_

Signature \_\_\_\_\_

### Membership Committee

Approved \_\_\_\_\_ Not Approved \_\_\_\_\_

Signature \_\_\_\_\_

## Membership Dues & Application Fees

~ All fees and dues must be enclosed with application for processing ~

Application Processing Fee \$ 150.00 one time fee only.

New Active Member Dues \$ 300.00 first year ~ after such time \$600.00 per yr.

For physicians who are practicing and are fully trained in neurology, neurosurgery, orthopaedics and all physicians in other specialties practicing in fields related to neurology and orthopaedics. New members will enjoy all benefits of membership.

## Contact Information: *Please clip a passport photo of yourself to the application.*

~ Please Print ~

NAME: \_\_\_\_\_ Degree: \_\_\_\_\_  
(Last) (First) (M)

BUS. ADDRESS: \_\_\_\_\_  
(Address) (City) (State) (Zip)

BUS. PHONE: \_\_\_\_\_ BUS. FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

\*HOME ADDRESS: \_\_\_\_\_  
(Address) (City) (State) (Zip)

\*HOME PHONE: \_\_\_\_\_ \*HOME FAX: \_\_\_\_\_ \*DATE OF BIRTH: \_\_\_\_\_

PRIMARY SPECIALTY: \_\_\_\_\_ \*SECONDARY SPECIALTY: \_\_\_\_\_

\*CURRENT AMERICAN MEDICAL ASSOCIATION MEMBER: YES \_\_\_\_\_ NO: \_\_\_\_\_

**Contact information maybe published on the AANOS Website, JONOMS and Membership Directory.**

**Please indicate below your preference for published information.**

(\* Information will not be published)

- Yes, You may publish my business information  
 No, I do not wish to have my business information published

Over →

**Medical Education: Attach All Certificates: Medical School Graduation and Training Certificates.**

MEDICAL SCHOOL: \_\_\_\_\_  
(Name of School) (City, State/Country) (Dates: From-To MM/YY)

INTERNSHIP: \_\_\_\_\_  
(Hospital) (Complete Address) (Dates: From-To MM/YY)

GENERAL SURGERY: \_\_\_\_\_  
(Hospital) (Complete Address) (Dates: From-To MM/YY)

**Residency: Attach All Residency Certificates.**

1<sup>st</sup> Year: \_\_\_\_\_  
(Hospital) (Complete Address) (Dates: From-To MM/YY)

2<sup>nd</sup> Year: \_\_\_\_\_  
(Hospital) (Complete Address) (Dates: From-To MM/YY)

3<sup>rd</sup> Year: \_\_\_\_\_  
(Hospital) (Complete Address) (Dates: From-To MM/YY)

4<sup>th</sup> Year: \_\_\_\_\_  
(Hospital) (Complete Address) (Dates: From-To MM/YY)

**Please Answer the Following: \*If the answer to any of the below questions is Yes, please explain on your business letterhead and attach to this application. Attach a Copy of All-Medical License(s), DEA License and Pharmacy License(s).**

1. Have you ever had your medical license, pharmacy, or DEA license reclassified, suspended, restricted or revoked?	<input type="radio"/> Yes *	<input type="radio"/> No
2. Have you had a physical, emotional, alcohol/substance abuse problem that may impair your judgement or performance?	<input type="radio"/> Yes*	<input type="radio"/> No
3. Have you been subject to a disciplinary action by a medical society, hospital, or board?	<input type="radio"/> Yes*	<input type="radio"/> No
4. Have your privileges, medical or surgical, been revoked or curtailed by any hospital?	<input type="radio"/> Yes*	<input type="radio"/> No

**Membership Participation:**

I am willing to present abstracts for the Annual Scientific Meetings.	<input type="radio"/> Yes	<input type="radio"/> No
I am willing to submit articles for Publication in the Journal of Neurological & Orthopaedic Medicine and Surgery (JONOMS).	<input type="radio"/> Yes	<input type="radio"/> No
I agree to attend one Annual Scientific Meeting at least every three years in order to maintain my membership status.	<input type="radio"/> Yes	<input type="radio"/> No

**To complete this application, please enclose two letters of recommendation from colleagues in your specialty. This letter must be on their letterhead with contact information and must include dates of practice observation and signature.**

**~ Enclosure & Attachments Checklist ~**

**Referred**

◇ Application Processing Fee \$ 150.00	◇ New Member Dues \$ 300.00	◇ Passport Photo
◇ Medical School Certificate	◇ All Training & Residency Certificates	◇ 2 Colleague Recommendation Letters
◇ Current Curriculum Vitae (Resume)	◇ All State Medical License(s)	◇ DEA & Pharmacy License(s)

*I hereby certify that under penalty of perjury by law, the aforementioned are all true and there is no ill intent or bad faith involved in my application for membership. I also understand that any falsifications of reports, misrepresentations of material, significant omissions, dishonesty, forgery, and unethical practices will automatically render my application null and void. I moreover agree to comply with the By-Laws 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 admits students of any race, color, national origin, sex, age, handicap or religious preference in its educational program, activities, and employment as required by the Civil Rights Act of 1964 and the Amendments including Title IX of the Educational Amendments of 1972.