

APPLICATION FOR MEMBERSHIP

Allied Health/Associate Member – Basic Sciences

MEMBERSHIP CRITERIA CHECKLIST

- Non-surgeon professional* or PhD
- Engaged in foot and ankle orthopaedic surgery or research

* Nurse, nurse practitioner, physician assistant, orthopaedic technician, physical therapist, athletic trainer, orthotist/pedorthist, or prosthetist

Submission deadlines: Applications are accepted throughout the year via email or mail. The AOFAS Board of Directors approves applications on a monthly basis.

SUBMISSION REQUIREMENTS CHECKLIST

- Completed application form including signature
- Current Curriculum Vitae
- One signed letter of sponsorship from an AOFAS Active Member or International Member
- Copy of graduate degree and/or certification(s)
- Digital headshot photo (color preferred)

Annual dues: \$250 (US funds)

A prorated invoice will be provided upon membership approval.

PLEASE PRINT. All information must be provided in English.

Name _____
Last First Middle Name or Initial Suffix

NPI _____ Degree(s) _____ Credential(s) _____

Date of Birth mm / dd / yy Informal First Name _____ Name for Certificate _____

Gender: Male Female Transgender Female Transgender Male Gender Variant/Non-Conforming Prefer Not to Answer

Race: American Indian/Alaska Native Asian Black/African American Hispanic/Latino Native Hawaiian/Other Pacific Islander
 Middle Eastern/North African White Non-US Native None of the Above Prefer Not to Answer

Preferred FAI Mailing Address: Office Home **Primary Email Address:** Office Home

American Medical Association Member? Yes No **American College of Surgeons Member?** Yes No

OFFICE CONTACT INFORMATION

Practice/University/Facility Name _____

Department _____ Job Title _____

Street Address _____ Building or Suite _____

City/Region _____ State/Province _____ ZIP/Postal Code _____ Country _____

Phone _____ Fax _____
Country Code City Code Area Code Number Country Code City Code Area Code Number

Website _____ Email _____

Office Assistant Name _____ Email _____ Phone Extension _____

HOME CONTACT INFORMATION

Street Address _____ Apartment or Unit _____

City/Region _____ State/Province _____ ZIP/Postal Code _____ Country _____

Phone _____ Cell Phone _____
Country Code City Code Area Code Number Country Code City Code Area Code Number

Email _____

Colleague Contact – AOFAS Members may log in to the members-only section of the website to obtain colleague contact information including work address and phone, email addresses, and home and cell phone numbers if permitted for release.

- Check here if you DO NOT want your home phone made available to AOFAS members
- Check here if you DO NOT want your cell phone made available to AOFAS members

American Orthopaedic Foot & Ankle Society Allied Health/Associate Member – Basic Sciences

EDUCATION

Name of Graduate School or Institution _____

City, State, Country _____ Degree _____

Year of Graduation (e.g. 2000) _____ Field _____

Residency or Fellowship (if applicable)

Residency Program _____ Fellowship Program _____

Time Period _____ to _____ Time Period _____ to _____

Practice/University/Institution _____ Practice/University/Institution _____

Area of Focus _____ Area of Focus _____

Certifications

Certification _____ Year Received _____ Certification _____ Year Received _____

Name of School or Organization _____ Name of School or Organization _____

City, State, Country _____ City, State, Country _____

Brief statement on your research interest area, if applicable (maximum 35 words)

PROFESSIONAL EXPERIENCE

Do you hold a faculty position at a university? Yes No

If yes, please indicate your title _____

SPONSORSHIP

A current AOFAS Active or International Member must provide a letter of sponsorship on your behalf.

Sponsor Name _____

Letter of sponsorship should be signed and sent directly by its author via email or mail:

Email: membership@aofas.org

Mail: AOFAS, 9400 W. Higgins Road, Suite 220, Rosemont, IL 60018-4975

AGREEMENT

By signing below, I attest that the above information is true. I understand that completion and submission of this application form provides written permission for the AOFAS to make inquiries and investigate as it deems necessary to verify my credentials and professional standing. I acknowledge that my name and work mailing address may be provided to third parties approved for list rental.

Signature _____ Date _____ / _____ / _____
mm dd yy

SUBMISSION

Please submit this application and other application materials (identified in the Submission Requirements Checklist on the first page of this application) to AOFAS via email or mail:

Email: membership@aofas.org

Mail: AOFAS, 9400 W. Higgins Road, Suite 220, Rosemont, IL 60018-4975

Questions? Contact AOFAS Membership at 800-235-4855 or +1-847-698-4654.

Upon receipt of all application requirements, your documents will be reviewed by the AOFAS Membership Committee and then your name will be presented for final approval to the Board of Directors. You will be informed of the review progress as it proceeds and notified when your membership has been approved. At that time, your prorated dues notice will be sent and your member benefits will begin. Your subscription to *Foot & Ankle International* will begin upon payment of membership dues.

Thank you for your interest in the American Orthopaedic Foot & Ankle Society.