AMERICAN ORTHOPAEDIC FOOT & ANKLE SOCIETY®

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, fax, 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 (e.g. Jr. or II)

NPI __________________ **Credentials** __________________ **Degrees** __________________

Informal First Name __________________ **Name for Certificate** __________________

Date of Birth _______ / _______ / _______ **Sex:** ☐ **Male** ☐ **Female** ☐ **Prefer Not to Answer**
mm dd yy

Preferred *FAI* Mailing Address: ☐ Office ☐ Home **Preferred Dues Mailing Address:** ☐ Office ☐ Home

Primary Email Address: ☐ Office ☐ Home

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

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Applicant Name ______________________________

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 ______________________________

Time Period ______________ to ______________

Practice/University/Institution ______________________________

Area of Focus ______________________________

Fellowship Program ______________________________

Time Period ______________ to ______________

Practice/University/Institution ______________________________

Area of Focus ______________________________

Certifications

Certification ______________ Year Received ______________

Name of School or Organization ______________________________

City, State, Country ______________________________

Certification ______________ Year Received ______________

Name of School or Organization ______________________________

City, State, Country ______________________________

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

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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, fax, or mail:

Email: membership@aofas.org • Fax: 847-692-3315
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 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, fax, or mail:

Email: membership@aofas.org • Fax: 847-692-3315
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 subscription to *Foot & Ankle International* and all other member benefits will begin.

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