



# APPLICATION FOR MEMBERSHIP

## Surgeon in Training

### MEMBERSHIP CRITERIA CHECKLIST

- MD or DO practicing within the US or Canada
- Enrolled in an orthopaedic fellowship program or an orthopaedic surgery residency training program
- Resident or Fellow Member of the AAOS, AOA, or COA (Canadian Orthopaedic Association)

Member ID: \_\_\_\_\_

- Interested in the advancement of orthopaedic knowledge of the treatment and conditions of the foot and ankle

### SUBMISSION REQUIREMENTS CHECKLIST

- Completed application form signed by you as well as your residency training or fellowship program director
- Current Curriculum Vitae
- Digital professional photo (color preferred)

Annual dues: \$100 (US funds)

A prorated invoice will be provided upon membership approval.

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

### PLEASE PRINT. All information must be provided in English.

Name \_\_\_\_\_ Degrees:  MD  DO Other: \_\_\_\_\_  
Last First Middle Suffix

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Informal First Name \_\_\_\_\_ NPI \_\_\_\_\_  
mm dd yy

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

Ethnicity:  American Indian/Alaska Native  Asian  Black/African American  Hispanic/Latino  Native Hawaiian/Other Pacific Islander  White  Non-US Native

Preferred FAI Mailing Address:  Office  Home Preferred Dues 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 \_\_\_\_\_

### 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

**Continued on next page**

## American Orthopaedic Foot & Ankle Society Surgeon in Training

### EDUCATION AND TRAINING

**Name of Medical School** \_\_\_\_\_

City, State, Country \_\_\_\_\_

Year of Graduation (e.g. 2010) \_\_\_\_\_

**Orthopaedic Residency**

Program/Institution Name \_\_\_\_\_

Year of Completion (actual or expected) \_\_\_\_\_

City, State, Country \_\_\_\_\_

Residency Training Director Name \_\_\_\_\_

Other Residency Training, if any \_\_\_\_\_

**Other Degrees (if applicable)**

Degree \_\_\_\_\_ Year Received \_\_\_\_\_

Name of School or Institution \_\_\_\_\_

City, State, Country \_\_\_\_\_

**Foot & Ankle Fellowship (if applicable)**

Program/Institution Name \_\_\_\_\_

Year of Completion (actual or expected) \_\_\_\_\_

City, State, Country \_\_\_\_\_

Fellowship Director Name \_\_\_\_\_

Other Fellowship Training, if any \_\_\_\_\_

**Other Degrees (if applicable)**

Degree \_\_\_\_\_ Year Received \_\_\_\_\_

Name of School or Institution \_\_\_\_\_

City, State, Country \_\_\_\_\_

### SPONSORSHIP

**Name of Residency Training Director or Fellowship Program Director** \_\_\_\_\_

Director Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm dd yy

### 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 understand that membership in this category shall be for no more than six (6) years and will conclude after my last year of formal residency training or completion of foot and ankle fellowship. 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](mailto: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 (outside US).

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.**