AMERICAN ORTHOPAEDIC FOOT & ANKLE SOCIETY®

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, AOAO, 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 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 ____/____/____ (mm dd yy) **Informal First Name** ____________________ **NPI** ____________________

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 ______________________________ (Country Code, City Code, Area Code, Number) **Fax** ______________________________ (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 ______________________________ (Country Code, City Code, Area Code, Number) **Cell Phone** ______________________________ (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

Applicant Name ______________________________

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 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 (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 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.