408 Kenwood Avenue
Delmar, New York 12054
Tel: (518) 439-2020 • Fax: (518) 439-2040
E-mail: nyssohns@aol.com
Website: www.nyssohns.org

APPLICATION FOR MEMBERSHIP

Check Category:

- ❒ Practicing $150
- ❒ First Year Practice $100
- ❒ Fellow $25
- ❒ Resident $25

PERSONAL INFORMATION

Name: ____
(Last) *(First)* *(Middle Initial)*

Title (check all that apply): ❒ MD ❒ DO ❒ PhD ❒ JD ❒ Other: ______________

Home Address: ____
(Street) *(City)* *(State)* *(Zip)*

Home Phone: ( ) ______________ Date of Birth: ______________

Business Email: ______________ Alternate Email: ______________

PRACTICE INFORMATION

Practice Name: ____

Primary Office Address: ____
(Street) *(City)* *(State)* *(Zip)*

Phone: ( ) ______________ Fax: ( ) ______________

Satellite Office Address: ____
(Street) *(City)* *(State)* *(Zip)*

Phone: ( ) ______________ Fax: ( ) ______________

Medical License No: ______________ State Issued: ______________ Exp. Date: ______________

Number of Years in Practice: ______________

Type of Practice:
- ❒ Solo Private Practice
- ❒ Group Private Practice
- ❒ Hospital-Based
- ❒ University-Based
- ❒ HMO

Subspecialty/Practice Focus:
(Fellowship trained or $\geq$50% of practice)
- ❒ Otology/Neurotology
- ❒ Pediatric Otolaryngology
- ❒ Head and Neck
- ❒ Rhinology
- ❒ Laryngology
- ❒ Facial Plastic & Reconstructive Surgery
- ❒ Allergy
- ❒ Other ______________

(OVER)

Hospital Appointments: ____

____

EDUCATION

Premedical Education: ______________________ Degree: __________ Completion Date: __________
(College or University)

Medical School: ______________________ Completion Date: __________

Residency: ______________________ Completion Date: __________

Fellowship(s): ______________________ Completion Date: __________

____

ABO Certification: ❒ Yes ❒ No Year: ________ (If no, are you eligible? Yes No)

Other certification: ❒ Yes ❒ No (If yes, by whom: ______________________)

PROFESSIONAL/HONORARY AFFILIATIONS

Medical Society Memberships:

- ❒ American Academy of Otolaryngology - Head and Neck Surgery
- ❒ American Medical Association
- ❒ Medical Society of the State of New York
- ❒ Regional Otolaryngology Society
- ❒ Other: ______________________

AREAS OF INTEREST

Check all that apply:

- ❒ Third Party Payer Issues
- ❒ State Legislation
- ❒ Federal Legislation
- ❒ Membership
- ❒ Public Education
- ❒ Clinical Education
- ❒ Resident Advocacy Education
- ❒ Office Staff Education
- ❒ Other: ______________________

I hereby submit my application for membership in the New York State Society of Otolaryngology - Head and Neck Surgery and in signing this application agree to abide by the organization's By-laws.

Signature: ______________________ Date: __________