

# ***American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery***

4764 Fishburg Road, Suite F - Huber Heights, OH 45424  
(800) 455-9404 or (937) 233-5653 – Fax (937) 233-5673 – Email: [aocoohns@aol.com](mailto:aocoohns@aol.com)

Visit our website for additional residency information: [www.aocoohns.org](http://www.aocoohns.org)

To: Resident Non-Member or New Resident

## **IMPORTANT**

Information regarding your application for:

- Resident Membership
- New Member
- Fellow

To complete your application to the AOCOO-HNS for Resident Membership, submit the following:

- application form (legibly handwritten or typewritten, see below)
- photograph (black and white preferred)

Following the completion of each of your residency training years, the AOCOO-HNS Council of Medical Education (C.O.M.E.) meets to evaluate resident annual reports.

**A NON-MEMBER RESIDENCY EVALUATION FEE OF \$100.00 PER YEAR WILL APPLY TO THOSE RESIDENTS WHO CHOOSE NOT TO APPLY AND/OR MAINTAIN CANDIDATE MEMBERSHIP STATUS IN THE AOCOO-HNS.**

**RESIDENT REMINDER: Your annual residency reports are due 30 days following the completion of your training year. Go to [www.aocoohns.org](http://www.aocoohns.org) for copies of all reports.**

AMERICAN OSTEOPATHIC COLLEGES OF OPHTHALMOLOGY AND OTOLARYNGOLOGY-HEAD AND NECK SURGERY

**APPLICATION FOR MEMBERSHIP**

I HEREBY APPLY to the Board of Governors of the American Osteopathic Colleges of Ophthalmology and Otolaryngology-Head and Neck Surgery for classification of Member, and herewith enclose the Application Fee and First Year's Dues.

1. Name (in full) \_\_\_\_\_
2. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_
4. High School Education with Name of School \_\_\_\_\_  
Location \_\_\_\_\_ Year completed \_\_\_\_\_
5. Academic Degree \_\_\_\_\_ College \_\_\_\_\_ Year completed \_\_\_\_\_
6. Academic Degree \_\_\_\_\_ College \_\_\_\_\_ Year completed \_\_\_\_\_
7. Osteopathic Education: Degree \_\_\_\_\_ School \_\_\_\_\_ Year completed \_\_\_\_\_
8. Medical Degree \_\_\_\_\_ School \_\_\_\_\_ Year completed \_\_\_\_\_
9. Traditional Internship dates \_\_\_\_\_ Institution/Hospital \_\_\_\_\_  
Specialty Track Internship dates \_\_\_\_\_ Institution/Hospital \_\_\_\_\_
10. Specialty training in: \_\_\_\_\_ Ophthalmology \_\_\_\_\_ Otolaryngology \_\_\_\_\_ Facial Plastic Surgery \_\_\_\_\_ Other \_\_\_\_\_  
(a) Institution/Hospital \_\_\_\_\_ Dates \_\_\_\_\_  
(b) Program Director \_\_\_\_\_
11. Teaching appointments: Title \_\_\_\_\_  
School \_\_\_\_\_ Years \_\_\_\_\_  
School \_\_\_\_\_ Years \_\_\_\_\_
12. Length of time in private practice before taking up practice of Ophthalmology, Otolaryngology and/or Facial Plastic Surgery.  
Location \_\_\_\_\_ Dates \_\_\_\_\_  
Location \_\_\_\_\_ Dates \_\_\_\_\_
13. In addition to Ophthalmology, Otolaryngology and/or Facial Plastic Surgery, applicant is engaged in the treatment of the following:  
\_\_\_\_\_  
\_\_\_\_\_
14. Scientific papers relating to Ophthalmology, Otolaryngology and/or Facial Plastic Surgery written and published:  
Title: \_\_\_\_\_  
Journal: \_\_\_\_\_  
Title: \_\_\_\_\_  
Journal: \_\_\_\_\_
15. Name and address of two persons, preferably well known Ophthalmologists, Otolaryngologists and/or Facial Plastic Surgeons or physicians limiting to other specialties, from whom information may be obtained regarding the professional standing and character of the applicant:  
Name \_\_\_\_\_ Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
16. I hereby pledge myself to the highest ethical standards in the practice of Ophthalmology, Otolaryngology and/or Facial Plastic Surgery:  

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Information sheet for  
AOCOO-HNS Membership Directory**

(Please TYPE or PRINT clearly)

**NAME**

**NICKNAME**

**PHOTOGRAPH**

current photo attached  
 use one in file (if available)

**ADDRESS**

Email: \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

**BIRTHDATES**

Doctor: month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

Spouse: name \_\_\_\_\_ month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

Children: \_\_\_\_\_ month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

\_\_\_\_\_ month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

\_\_\_\_\_ month \_\_\_\_ day \_\_\_\_ year \_\_\_\_

**LICENSED**

in the following states

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HOSPITAL AFFILIATIONS**

Name \_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_

\_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_

\_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_

\_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_

\_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_

\_\_\_\_\_ city \_\_\_\_\_ state \_\_\_\_\_

**SERVICE**

professional, community, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEMBERSHIPS**

American Osteopathic Association A.O.A. # \_\_\_\_\_

National Associations (name) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State Associations (name) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Local Associations (name) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

**AOCOO-HNS Status**

New Member  Resident Member  
 Full Member  Fellow  
 Honorary Member

**HONORS**

Fellow (date) \_\_\_\_\_  Life  
 Distinguished Service Award (date) \_\_\_\_\_  
 Other: \_\_\_\_\_

**SPECIALTY**

Ophthalmology  Other \_\_\_\_\_  
 Otolaryngology  Facial Plastic Surg.

**OFFICE ADDRESS**

Street \_\_\_\_\_

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Fax ( \_\_\_\_\_ ) \_\_\_\_\_

**TIME ZONE**

Eastern  Central  Mountain  Pacific

**OFFICE HOURS**

Monday \_\_\_\_\_ Thursday \_\_\_\_\_  
Tuesday \_\_\_\_\_ Friday \_\_\_\_\_  
Wednesday \_\_\_\_\_ Saturday \_\_\_\_\_

**EDUCATION**

Academic/PreMed \_\_\_\_\_

\_\_\_\_\_

Date graduated \_\_\_\_\_

Medical School \_\_\_\_\_

\_\_\_\_\_

Date graduated \_\_\_\_\_

Internship (institution/hospital) \_\_\_\_\_

\_\_\_\_\_

Date graduated \_\_\_\_\_

Residency (institution/hospital) \_\_\_\_\_

\_\_\_\_\_

Date graduated \_\_\_\_\_

Other (institution/hospital) \_\_\_\_\_

\_\_\_\_\_

Date graduated \_\_\_\_\_