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

Visit our website for additional residency information: www.aocoohns.org

To: Resident Non-Member or New Resident

IMPORTANT

Information regarding your application for:

[X] Resident Membership
New Member
Fellow

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

[X] application form (legibly handwritten or typewritten, see below)
[X] photograph (black and white preferred)
[X] a one time application fee of $50.00
[X] current yearly dues of $50.00

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.

METHOD OF PAYMENT

_____ Check   Make check payable to: AOCOO-HNS

_____ Credit Card   ___ Visa ___ MasterCard ___ Discover ___ AmericanExpress

Account # ________ ________ ________ ________

Exp. Date ________ ________ 3 digit code ___ ___ ___
(security code on back of credit card)

RESIDENT REMINDER: Your annual residency reports are due 30 days following the completion of your training year. Go to 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.

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MEMBERSHIPS

[ ] American Osteopathic Association A.O.A. # ___________

[ ] National Associations (name) ______________________

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[ ] State Associations (name) ________________________

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[ ] Local Associations (name) ________________________

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____

[ ] 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 ___________________________