AHNS

AMERICAN HEAD AND NECK SOCIETY

APPLICATION FOR MEMBERSHIP

AHNS Membership Services
11300 W Olympic Blvd #600
Los Angeles CA 90064
Phone: 310-437-0559 ext. 126
Fax: 310-437-0585
Email : membership@ahns.info
Web Site : www.ahns.info

Application Date: _____

PLEASE TYPE OR PRINT CLEARLY

PROPOSED CLASS OF MEMBERSHIP CATEGORY (PLEASE CHECK ONE):

- ☐ **ACTIVE** – Surgical applicant must be Diplomat of American Board of Surgery, Otolaryngology, Plastic Surgery or other equivalent certification board; FACS, FRCS or equivalent non-surgical organization; board certified oncologists. (Membership Dues: $400 USD annually).
- ☐ **ASSOCIATE** – Applicant must be a physician, dentist or scientist with special interest contributions in the field of neoplastic or traumatic diseases of the head and neck. (Membership Dues: $100 USD annually).
- ☐ **CANDIDATE** – Trainee currently enrolled in approved residency program in Otolaryngology, Plastic Surgery or General Surgery; in fellowship program approved by the Advanced Training Council. (Membership Dues: $25 USD annually).
- ☐ **CORRESPONDING** – Physician who specializes in treatment of head and neck cancer, who by professional associations and publications, is qualified to treat head and neck cancer; resides in a country other than USA or Canada. (Membership Dues: $100 USD annually).

REQUIRED APPLICATION DOCUMENTS CHECK LIST:

All membership categories:

- Submit a copy of your most current CV.
- Submit a 2x2 or passport size PHOTO.
- Two (2) LETTERS OF RECOMMENDATION from AHNS Active members (one in your community). International applicants may request letters from an AHNS Active or Corresponding member.
- $25 APPLICATION FEE.

Active member applicants only:

- CASE LIST with 35 most recent cases signed by Chief of Service or Department Chairman or Division Chair.

PLEASE NOTE: If the applicant has completed an approved ATC Fellowship Program within three (3) years of application, a case list is not required.

APPLICANT'S FULL NAME:

_____

(**LAST**/FAMILY NAME) (**FIRST**/GIVEN NAME) (**MIDDLE** NAME OR INITIAL)

☐ MD ☐ DMD ☐ DDS ☐ DO ☐ PhD ☐ Other Degrees: _____

Date of Birth (month/day/year): _____ Gender: **M** **F** Country of Birth: _____

PROFESSIONAL ADDRESS:

_____

(Association or Institution)

_____

(Department)

_____

(Street Address)

_____

(Street Address)

_____

(City) (State/Province) (Zip/Postal Code) (Country)

_____

(Telephone Number) (Fax Number) (E-Mail Address)

MEDICAL EDUCATION:

1) **Pre-Medical School**: Institution | Date Started | Date Graduated | Degrees

2) **Medical School**: Institution | Date Started | Date Graduated

3) **Internship**: Institution | Date Started | **Date To Be Completed?** | Type of Service

4) **Residency**: Institution | Date Started | **Date Completed/To Be Completed?** | Type of Service

5) **Fellowships**: Institution (Check one below or give other name) **Date Started** **Date Completed/To Be Completed?**

- ☐ Arthur G. James Cancer Hosp & Richard J. Solove Research Inst – Columbus OH
- ☐ Beth Israel Medical Center – New York NY
- ☐ Cleveland Clinic Foundation – Cleveland OH
- ☐ Emory University School of Medicine – Atlanta GA
- ☐ Georgia Regents University – Augusta GA
- ☐ Indiana University School of Medicine – Indianapolis IN
- ☐ Johns Hopkins University – Baltimore MD
- ☐ Massachusetts Eye and Ear Infirmary/Harvard Medical School – Boston MA
- ☐ Medical University of South Carolina – Charleston SC
- ☐ Memorial Sloan-Kettering Cancer Center – New York NY
- ☐ Mount Sinai School of Medicine/Tisch Cancer Center – New York NY
- ☐ Oregon Health & Sciences University – Portland OR
- ☐ Roswell Park Cancer Institute – Buffalo NY
- ☐ Southern Illinois University/Simmons Cooper Cancer Inst – Springfield IL
- ☐ Stanford University Medical Center – Stanford CA
- ☐ Thomas Jefferson University – Philadelphia PA
- ☐ University of Alabama Birmingham – Birmingham AL
- ☐ University of Alberta – Edmonton AB Canada
- ☐ University of California Davis – Sacramento CA
- ☐ University of California San Francisco – San Francisco CA
- ☐ University of Cincinnati Medical Center – Cincinnati OH
- ☐ University of Iowa Hospitals & Clinics – Iowa City IA
- ☐ University of Kansas School of Medicine – Kansas City KS
- ☐ University of Manitoba – Winnipeg MB Canada
- ☐ University of Miami Hospital & Clinic – Miami FL
- ☐ University of Michigan – Ann Arbor MI
- ☐ University of Nebraska Medical Center – Omaha NE
- ☐ University of Oklahoma HSC – Oklahoma City OK
- ☐ University of Penn Health System – Philadelphia PA
- ☐ University of Pittsburgh Medical Center – Pittsburgh PA
- ☐ University of South Florida – Tampa FL
- ☐ University of Toronto – Toronto ON Canada
- ☐ University of Washington – Seattle WA
- ☐ UTMD Anderson Cancer Center – Houston TX
- ☐ Wayne State University – Detroit MI
- ☐ Other _____

6) **Post Residency Experience** Date Started Date Completed/**To Be** Completed

LICENSURE AND BOARD CERTIFICATION:

Medical License Number | State/Province/Country | Date Issued

Board Certification Number | Specialty Board | Date Issued

Surgeons Only: FACS FRCS Equivalent Date of Induction

EXPERIENCE:

Past and Present Hospital Appointments (Name and location of hospital, medical staff position and dates):

Academic Appointments (Name and location of institution, staff position and dates):

Medical/Surgical Society Memberships:

_____

_____

POST GRADUATE COURSES (Name of medical school or sponsoring body, specialty or subjects, dates):
Attach additional sheet if needed

_____

_____

_____

CONTRIBUTIONS TO MEDICAL LITERATURE (Attach additional sheet or include in CV):

_____

_____

_____

SPONSORS (See sponsor requirements on front page under Required Documents):

_____

Name (PLEASE PRINT) **City/State or Country**

_____

Name (PLEASE PRINT) **City/State or Country**

PLEASE ENCLOSE $25 USD APPLICATION FEE:

☐ A check (USD only) is enclosed with this application. Please make checks payable to AHNS or American Head and Neck Society.
☐ I authorize you to charge my: ☐ VISA ☐ MasterCard

CC Number: _____ Expiration Date: _____ CVV:_____ Amount: _____

Cardholder Name: _____ Signature: _____

Attach a 2X2
photograph
in this space

Required for Active Membership Applicants <u>ONLY</u>
Case Listing is Attached
☐ Yes ☐ No
Note: Please indicate total number of patients with head and neck cancer cared for in the reported year.

Signature: _____

Date: _____