



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. 110
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 Diplomate 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: \$300 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): _____ 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 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	
<input type="checkbox"/> University of Michigan – Ann Arbor MI <input type="checkbox"/> Wayne State University – Detroit MI <input type="checkbox"/> Arthur G. James Cancer Hsp & Richard J. Solove Research Inst – Columbus OH <input type="checkbox"/> University of Cincinnati Medical Center – Cincinnati OH <input type="checkbox"/> University of Iowa Hospitals & Clinics – Iowa City IA <input type="checkbox"/> Southern Illinois University/Simmons Cooper Cancer Inst – Springfield IL <input type="checkbox"/> University of Kansas School of Medicine – Kansas City KS <input type="checkbox"/> University of Nebraska Medical Center – Omaha NE <input type="checkbox"/> Memorial Sloan-Kettering Cancer Center – New York NY <input type="checkbox"/> Roswell Park Cancer Institute – Buffalo NY <input type="checkbox"/> Johns Hopkins University – Baltimore MD <input type="checkbox"/> University of Penn Health System – Philadelphia PA <input type="checkbox"/> University of Pittsburgh Medical Center – Pittsburgh PA	<input type="checkbox"/> University of California Davis – Sacramento CA <input type="checkbox"/> Stanford University Medical Center – Stanford CA <input type="checkbox"/> University of Washington – Seattle WA <input type="checkbox"/> University of Oklahoma HSC – Oklahoma City OK <input type="checkbox"/> UTMD Anderson Cancer Center – Houston TX <input type="checkbox"/> University of Alabama Birmingham – Birmingham AL <input type="checkbox"/> Medical University of South Carolina – Charleston SC <input type="checkbox"/> University of Miami Hospital & Clinic – Miami FL <input type="checkbox"/> University of South Florida – Tampa FL <input type="checkbox"/> University of Alberta – Edmonton AB Canada <input type="checkbox"/> University of Toronto – Toronto ON Canada <input type="checkbox"/> University of Manitoba – Winnipeg MB Canada		
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: _____ Amount: _____

Cardholder Name: _____ Signature: _____

Attach a 2X2
photograph
in this space

Required for Active Membership

Applicants ONLY

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 _____