WASHINGTON METROPOLITAN OTOLARYNGOLOGY HEAD AND NECK SOCIETY

Membership application

Name: _____
Last First Middle

Office Address: _____
_____

Office Phone: (_____)_____ Office Fax: (_____)_____

Email address: _____

Date of Birth: _____

School of Medicine: _____
From _____ to _____

General Surgery Internship: _____
From _____ to _____

Otolaryngology Residency: _____
From _____ to _____

Fellowship: _____
From _____ to _____

Licenses: _____
State and License Number

Has your license, medical society membership, or hospital medical staff privileges ever been suspended, restricted, revoked, or not renewed? ( ) no ( ) yes
If yes, please give the location, date, and reason: _____
_____

Active Hospital Staff Privileges: _____

Member of the AAO-HNS	( ) yes	( ) no
Otolaryngology Board Certified	( ) yes	( ) no
Board eligible?	( ) yes	( ) no

_____ _____
Signature Date

Annual membership dues $250. Please make check payable to Washington Metropolitan Otolaryngology Society