MEMBERSHIP APPLICATION
ARIZONA ORTHOPAEDIC SOCIETY

(**CHECK ONE**) ☐ **ACTIVE** ☐ **RESIDENT** ☐ **RETIRED**

NAME: _____
(Last) (First) (Middle)

ADDRESS: (OFFICE) _____
Clinic Name (if applicable) Address

(HOME) _____

(E-MAIL) _____

Prefer Mail sent to OFFICE ☐ **HOME** ☐

TELEPHONE: (OFFICE) _____ (HOME) _____

FAX: (OFFICE) _____ (HOME) _____

BIRTH DATE: _____ ARIZONA MEDICAL LICENSE #:_____

PRIMARY SPECIALTY_____ BOARD CERTIFIED? Y ☐ N ☐

SECONDARY SPECIALTY _____ BOARD CERTIFIED? Y ☐ N ☐

MEDICAL SCHOOL: _____

DEGREE: _____ YEAR OF GRADUATION: _____

INTERNSHIP: _____ DATES: _____ to _____

RESIDENCY: _____ DATES: _____ to _____

_____ DATES: _____ to _____

FELLOWSHIP (S): _____DATES: _____ to _____
Field School & Location

_____DATES: _____ to _____
Field School & Location

Memberships held in other medical associations:
☑ AMA ☑ ArMA ☑ County Society
OTHER: _____

ORTHOPAEDIC SPECIALTY OR FIELD OF INTEREST: *If you wish to be listed in the Society's web site specialty search area, please complete the back of this form.*

APPLICANT'S SIGNATURE: _____DATE: _____

PLEASE COMPLETE AND RETURN TO: THE ARIZONA ORTHOPAEDIC SOCIETY 810 West Bethany Home Road, Phoenix, AZ 85013, (602) 347-6901, (602) 242-2515 fax, patriceh@azmedassn.org

NAME: _____

SPECIALTY OR FIELD OF INTEREST

Please check up to three.

- ☐ **ALTERNATIVE/COMPLEMENTARY MEDICINE**
- ☐ **ARTHROPLASTY**
- ☐ **ARTHROSCOPIC SURGERY**
- ☐ **FOOT AND ANKLE**
- ☐ **GENERAL ORTHOPAEDIC SURGERY**
- ☐ **HAND**
- ☐ **HAND - CONGENITAL**
- ☐ **HIP**
- ☐ **ILIZROV - BONE LENGTHENING**
- ☐ **INFECTIONS**
- ☐ **JOINT REPLACEMENT**
- ☐ **KNEE**
- ☐ **MINIMALLY INVASIVE SURGERY**
- ☐ **NATIVE AMERICAN HEALTH**
- ☐ **ONCOLOGY - MUSCULOSKELETAL**
- ☐ **OSTEOPATHY**
- ☐ **OTHER (S)** _____

- ☐ _____
- ☐ **PEDIATRIC FRACTURES**
- ☐ **PEDIATRICS**
- ☐ **RECONSTRUCTIVE SURGERY**
- ☐ **REHABILITATION**
- ☐ **SHOULDER**
- ☐ **SHOULDER AND ELBOW**
- ☐ **SPINE**
- ☐ **SPORTS MEDICINE**
- ☐ **TEAM PHYSICIAN**
- ☐ **TRAUMA**
- ☐ **TUMORS**
- ☐ **WOUNDS**