

**2021 MEMBERSHIP APPLICATION
ARIZONA ORTHOPAEDIC SOCIETY**

(CHECK ONE) ACTIVE RESIDENT RETIRED

NAME: _____

CLINIC AND ADDRESS: _____

HOME ADDRESS: _____

EMAIL: _____

Prefer mail sent to: OFFICE HOME

PHONE: (OFFICE) _____ (HOME) _____

FAX: (OFFICE) _____ (HOME) _____

ARIZONA MEDICAL LICENSE #: _____

PRIMARY SPECIALTY: _____ BOARD CERTIFIED?

SECONDARY SPECIALTY: _____ BOARD CERTIFIED?

MEDICAL SCHOOL: _____

DEGREE: _____ YEAR OF GRADUATION: _____

INTERNSHIP: _____ DATES: _____ to _____

RESIDENCY: _____ DATES: _____ to _____

_____ DATES: _____ to _____

FELLOWSHIP(S) (FIELD, SCHOOL & LOCATION)

_____ DATES: _____ to _____

(FIELD, SCHOOL & LOCATION)

_____ DATES: _____ to _____

MEMBERSHIPS HELD IN OTHER MEDICAL ASSOCIATIONS:

AMA ArMA County Society

OTHER: _____

Please indicate specialties/fields of interest on next page.

APPLICANT'S SIGNATURE: _____ DATE: _____

PLEASE COMPLETE AND RETURN TO:

**ARIZONA ORTHOPAEDIC SOCIETY, 2401 W Peoria Ave, Ste 130, Phoenix, AZ
85029; phone: 602-347-6901; fax: 602-242-6283; ldibiase@azmed.org**

NAME: _____

SPECIALTY OR FIELD OF INTEREST

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