



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 SOCIETIES

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 information below.*

APPLICANT'S SIGNATURE: _____ DATE: _____

PLEASE COMPLETE AND RETURN TO: THE ARIZONA ORTHOPAEDIC SOCIETY, 2401 W Peoria Ave, Ste 315, Phoenix, AZ 85029, phone: 602-347-6901, kmuller@azmed.org_____

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

PEDIATRIC FRACTURES

PEDIATRICS

RECONSTRUCTIVE SURGERY

REHABILITATION

SHOULDER

SHOULDER AND ELBOW

SPINE

SPORTS MEDICINE

TEAM PHYSICIAN

TRAUMA

TUMORS

WOUNDS