



## APPLICATION FOR MEMBERSHIP

### INSTRUCTIONS

1. Please print or type and return completed application to: PAAA, 777 East Park Drive, P. O. Box 8820 Harrisburg, PA 17105-8820
2. Any questions call 888-633-5784. Fax 717-558-7841.
3. **Attach current curriculum vitae.**
4. Please list **two Active PAAA members** as references. The PAAA Administrative Office will send a reference for membership form to the physicians you have indicated:  
(1) \_\_\_\_\_ (2) \_\_\_\_\_
5. Enclose a check for \$125 payable to **PAAA** for your 1<sup>st</sup> year's dues. (Does not apply to training applicants). It will be refunded only if the application is denied.
6. Applications will go to the Membership Committee only when complete.
7. Applications must be received by April 20<sup>th</sup> and approved in order to attend the Annual June Meeting as a PAAA member.

### MEMBERSHIP CATAGORIES

Please indicate the category for which you are applying. The Membership Committee reserves the right to change the category in which you are classified.

- Active** - A physician allergist (MD or DO) who has successfully completed two years of fellowship in allergy and immunology. He or she is eligible to vote, hold elective office, and to serve in any capacity on committees.

Subspecialties - Choose one:  Adults only  All Ages  Children Only

Patients Age 5 and Above  Immunodeficiency

- Associate** - Non-allergist physician (MD or DO). He or she may serve as a member of a committee (but not as its chair), but may not vote or hold elective office.

- Training** - A physician (MD or DO) enrolled in a fellowship program in allergy and immunology. A training member may serve on a committee (but not as a chair), but may not vote, or hold elective office. Training members are not responsible for dues. Elevation from training to active membership requires notification of successful completion of the two year fellowship.

Program Director's signature: \_\_\_\_\_ Projected year of completion: \_\_\_\_\_

- Corresponding** - Any person of good character who evinces an interest in allergy is eligible to become a corresponding member. He or she may serve as a member of a committee (but not as chair), but may not vote, attend PAAA board or business meetings or hold office.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Office Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Telephone:( ) \_\_\_\_\_ Business Fax:( ) \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Home Phone:( ) \_\_\_\_\_ Email Address \_\_\_\_\_

May we send you e-mail alerts from PAAA?  Yes  No

Preferred Mailing Address:  Home  Business

**Education:**

College \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_ Degree \_\_\_\_\_

Medical School \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_ Degree \_\_\_\_\_

Residency: Type \_\_\_\_\_ Institution \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

Type \_\_\_\_\_ Institution \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

**Fellowship:** \_\_\_\_\_ Institution \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

Name/ Address of Program Director: \_\_\_\_\_

**Hospital Appointments:** (name, address)

\_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

**Academic Appointments:**

Title \_\_\_\_\_ School \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

Title \_\_\_\_\_ School \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

Title \_\_\_\_\_ School \_\_\_\_\_ Date: \_\_\_\_\_ to \_\_\_\_\_

**State Medical License:** (provide date of licensure and license number):

1. \_\_\_\_\_ 2. \_\_\_\_\_

**Board Certification:**

ABIM/ABP (circle) Date \_\_\_\_\_ Certificate # \_\_\_\_\_

A & I Date \_\_\_\_\_ Certificate # \_\_\_\_\_

(If not certified, date of eligibility) \_\_\_\_\_

Other (specify) \_\_\_\_\_

Date \_\_\_\_\_ Certificate # \_\_\_\_\_

**Membership in Medical Organizations:**

AAAAI \_\_\_\_\_  ACAAI \_\_\_\_\_ Other \_\_\_\_\_

**Have you ever had your license to practice medicine or hospital privileges revoked or suspended?**

Yes  No . If yes, please explain on a separate sheet of paper.

I hereby pledge myself to the highest ethical standard in the practice of medicine; I agree to abide by the rules and regulations of the Association and Bylaws and by such changes and amendments as may hereafter be properly adopted. I agree to revocation of the certificate of membership in this Association in the event that any of the statements made relevant to this application by me are false. I agree to hold the Association, its members, officers, and agents free from any damage or complaint by reason of any action they or any of them may take in connection with this application.

\_\_\_\_\_  
(Signature of Applicant)

\_\_\_\_\_  
(Date)