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 717-558-7750 x1592. Fax 717-558-7841.
3. **Attach current curriculum vitae.**
4. Enclose a check for $125 payable to **PAAA** for your 1st year's dues, plus a $125 reapplication fee if your membership has previously been dropped. (Does not apply to training applicants). It will be refunded only if the application is denied.
5. Applications will go to the Membership Committee only when complete.
6. Applications will be reviewed by the board three times per year; winter, summer & fall.

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: ____

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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)

revised 07/ 12/ 10

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