



AMERICAN ASSOCIATION FOR HAND SURGERY Affiliate Membership Application

INSTRUCTIONS TO APPLICANTS FOR AFFILIATE MEMBERSHIP

Affiliate membership may be conferred on individuals of the medical profession, basic science or allied services whose interests and contributions are related to the advancement of hand surgery and hand therapy and who have the following qualifications:

- a. Graduation or completion of training from an accredited university training program.
- b. Certification, registration or licensure by their specific state, national organization (i.e. P.T., O.T.) or Board of specialty, if applicable.
- c. Specialized training relating to hand care, one year of on-the-job training, or adequate continuing education.
- d. A minimum of one year active practice.
- e. Adequate experience in caring for the hand, such experience to be evaluated by the Membership Committee and Board of Directors.

INSTRUCTIONS

1. Complete the enclosed application form and attach the following:
 - a. Passport size photograph.
 - b. A copy of the certificate or letter from the certifying board or registering or licensing body verifying certification/license/credentials.
 - c. One professional reference to include name and contact information.
 - d. Copy of CV (should include publications and presentations.)
 - e. Only completed applications will be accepted.
2. FAILURE TO FOLLOW THESE GUIDELINES EXACTLY WILL CAUSE YOUR APPLICATION TO BE RETURNED IN ORDER TO OBTAIN COMPLIANCE, AND MAY DELAY APPROVAL OF YOUR APPLICATION.
3. Please send completed applications to:

**American Association for Hand Surgery
444 East Algonquin Road
Arlington Heights, IL 60005-4664
Email: mmichelotti@handsurgery.org**

AAHS

AFFILIATE MEMBERSHIP APPLICATION

If you are interested in applying for affiliate membership, please follow the instructions provided.

PERSONAL INFORMATION

Name _____ Date _____

Date of Birth _____ Place of Birth _____

Address:

Office _____ City _____ State _____ Zip _____

Office Phone _____ Office Fax _____ E-mail _____

Home _____

City _____ State _____ Zip _____

Home Phone _____ Home Fax _____

Home Email _____

PROFESSIONAL QUALIFICATIONS

University/College _____ Degree _____ Date _____

Graduate School _____ Degree _____ Date _____

Medical School _____ Degree _____ Date _____

Clinical Practice _____

Hospital Staff Appointments _____

(names and addresses) _____

Hand Therapy Certification _____ Date _____

Board Certification _____ Date _____

Specialty Board

Certification _____ Date _____

Licensure:

Number _____ State _____

or

Registry

Any investigations pending Yes _____ No _____

Any license revocations or restrictions Yes _____ No _____

Any felony convictions Yes _____ No _____

In furtherance of my application for membership in the American Association for Hand Surgery (AAHS), I hereby authorize the evaluation and validation of my credentials by AAHS in accordance with and subject to the rules and procedures of the AAHS.

I request and authorize any hospital, medical staff, medical organization or individual who may have information (including, but not by way of limitation, medical records, patient records, and reports of committees) which they deem relevant to my fitness for membership in AAHS to provide such information to AAHS.

I hereby release from liability and waive any claim for damages that I may have against AAHS, its officers, directors, members, employees and agents for any acts that they may perform in good faith in connection with my application, and any hospital, medical staff, medical organization or individual supplying information with respect to my application.

I understand that the decision as to whether I am qualified to be submitted to AAHS membership for election rests solely and exclusively in the AAHS Board of Directors, and that its decision is final.

I further understand that my election to membership rests solely and exclusively in the membership of AAHS, and that its decision is final.

I attest that the information presented in this application is truthful and accurate.

Signature _____ Date _____

Make checks for application fee payable to AAHS and mail with the completed form to the central office.

Return completed application to:

**AMERICAN ASSOCIATION FOR HAND SURGERY
444 EAST ALGONQUIN ROAD
ARLINGTON HEIGHTS, ILLINOIS 60005-4664**

**PLEASE PLACE
PHOTOGRAPH
HERE**