



AMERICAN ASSOCIATION FOR HAND SURGERY International Membership Application

INSTRUCTIONS TO APPLICANTS FOR INTERNATIONAL MEMBERSHIP

International membership may be conferred by the Board of Directors on hand surgeons who reside and practice in countries other than the United States and Canada, who have achieved distinction in surgery in their own country, and who are members in good standing of their national surgical organization(s). All candidates must satisfy the following qualifications:

- a. Training in hand surgery in an accredited residency or fellowship program.
- b. A minimum of one year active practice, with adequate experience in hand surgery, such experience to be determined by the Board of Directors and evaluated by the Membership Committee.
- c. Demonstration and verification of competence in hand surgery according to standards determined by the Board of Directors and evaluated by the Membership Committee.

INSTRUCTIONS

1. Complete the enclosed application form and attach the following:
 - a. Application fee of \$75.00. Checks should be made out to AAHS.
 - b. Passport size photograph.
 - c. A copy of the certificate or letter from the certifying board verifying board certification.
 - d. One (1) letter of recommendation; from an active member of AAHS (can be sent via email).
 - e. Copy of CV (should include publications and presentations.)
 - f. 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
INTERNATIONAL MEMBER

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

Application – International Membership – Fee \$75.00

PERSONAL INFORMATION

Name _____ Date _____

Date of Birth _____ Place of Birth _____

Address:

Office _____ City _____ State _____ Zip _____

Office Phone _____ Office Fax _____ Email _____

Home _____ City _____ State _____ Zip _____

Home Phone _____ Home Fax _____

Home Email _____

PROFESSIONAL QUALIFICATIONS

University _____ Degree _____ Date _____

Medical School _____ Degree _____ Date _____

Residency _____ Degree _____ Date _____

Hand Fellowship (not mandatory) _____

Preceptors: 1. _____ 2. _____

Licensure:

Number _____ State _____

Board Certification (include CAQ's) _____

ECFMG/FLEX _____

Academic Appointments

1. _____ 2. _____

Hospital Affiliations (names and addresses):

Hand Cases Last Year: # _____

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**