

## BECOME A MEMBER

### Application for Membership

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Credentials: \_\_\_\_\_

Practice Name: \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

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

Select Your Membership Category: \_\_\_\_\_ Regular Member - \$100/yr

\_\_\_\_\_ Sustaining Member, fee waived for retired physicians

*You may send a copy of your CV or fill in the following information*

**Training to include Medical School, Residencies, Post Graduate Training, and Special**

**Training in Otolaryngology (dates in chronological order):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Present Appointments – Hospital and teaching:** \_\_\_\_\_

\_\_\_\_\_

**Date of Beginning Exclusive Practice of Otolaryngology in the State of Arkansas:** \_\_\_\_\_

**Certified by American Board of Otolaryngology:** \_\_\_\_\_Yes \_\_\_\_\_No Eligible: \_\_\_\_\_

**Mail Membership Form and Payment to:** University of Arkansas for Medical Sciences  
Department of Otolaryngology - HNS Attn: Brenda Speed

University of Arkansas for Medical Sciences

Department of Otolaryngology –

HNS 4301 West Markham, # 543

Little Rock, AR 72205

501-296-1157