NASBS

NORTH AMERICAN SKULL BASE SOCIETY

APPLICATION FOR MEMBERSHIP

NASBS Membership Services
11300 W Olympic Blvd #600
Los Angeles CA 90064
Phone: 310-424-3326 ext. 110
Fax: 310-437-0585
Email: membership@nasbs.org
Web Site: www.nasbs.org

Application Date: _____ PLEASE TYPE OR PRINT CLEARLY

PLEASE ACCEPT MY APPLICATION FOR THE FOLLOWING MEMBERSHIP CATEGORY (CHECK ONE):

☐ **ACTIVE** - I have earned a doctorate (MD, PhD or equivalent), certified by the American Board of Medical Specialties or equivalent, and engaged in practice 3 years or more with special clinical experience in field related to skull base surgery. **I have been in practice since Year: _____**. (Membership Dues: $275 USD annually).

☐ **INTERNATIONAL** - I possess a doctorate degree (MD, PhD or equivalent), satisfied the standards of my country fully qualified in area of specialty, and engaged in practice 3 years or more with special clinical experience in field related to skull base surgery, outside USA or Canada. **I have been in practice since Year: _____**.
___ Yes, I want to receive the journal – (Membership Dues: $275 USD annually).
___ No, I do not wish to receive the journal – (Membership Dues: $175 USD annually).

☐ **CANDIDATE** – I am a resident or fellow in good standing in a board-approved program *or* board-eligible or certified by American Board of Medical Specialties or equivalent, active in regional or national societies, but less than 3 years of practice**. Year Residency Complete: _____ Year Fellowship Complete: _____.** Until this time, I pay no annual dues.
___ Yes, I do wish to receive the journal – (Journal Subscription: $100 USD annually).
Annual dues of $275 USD will be paid to the NASBS for 3 years after finishing residency/fellowship.

☐ **AFFILIATE** - I have obtained an academic degree other than a doctorate degree (RN, LPN, and PA included) and a special interest/experience in research, treatment or testing in area related to skull base (Membership Dues: $275 USD annually).

APPLICANT'S FULL NAME:

_____

(**LAST**/FAMILY NAME) (**FIRST**/GIVEN NAME) (**MIDDLE** NAME OR INITIAL)

☐ MD ☐ DMD ☐ DDS ☐ DO ☐ PhD ☐ RN ☐ LPN ☐ PA ☐ Other Degrees: _____

Date of Birth (month/day/year): _____ Country of Birth _____

PROFESSIONAL ADDRESS:

_____

(Association or Institution)

_____

(Department)

_____

(Street Address)

_____

(City) (State/Province) (Zip/Postal Code) (Country)

_____

(Telephone Number) (Fax Number) (E-Mail Address)

MEDICAL EDUCATION:

Medical School: Institution	Date Started	Date Completed	
Residency: Institution	Date Started	Date Completed	Areas of Specialization
Fellowship: Institution	Date Started	Date Completed/To Be Completed	Areas of Specialization

EXPERIENCE:

Hospital Affiliations: _____

Teaching Program Affiliation: _____

Society Memberships (Abbreviate): _____

Are you board certified in your specialty? ___ No ___ Yes If yes, years of certification: _____

SPECIALTY:

☐ Otology/Neurotology	☐ Head & Neck Surgery	☐ Rhinology	☐ Maxillofacial Surgery
☐ Radiology	☐ Neurosurgery	☐ Pathology	☐ Plastic Surgery
☐ Radiation Oncology	☐ Ophthalmology		

☐ Other: _____

REFERENCES:

ACTIVE APPLICANT: Two Active NASBS members
INTERNATIONAL APPLICANT: Two active members from ANY International Society
CANDIDATE APPLICANT: Residents/Fellows: Two Active NASBS members, letter of good standing from Program Director
Finished program/fellowship, less 3 years practice: Two Active NASBS members
AFFILIATE: Two Active NASBS members *or* one Active and one Affiliate NASBS member

_____

Name (PLEASE PRINT) **City/State or Country**

_____

Name (PLEASE PRINT) **City/State or Country**

PLEASE ENCLOSE $100 USD APPLICATION FEE:

☐ A check (USD only) is enclosed with this application. Please make checks payable to NASBS.
☐ I authorize you to charge my: ☐ VISA ☐ MasterCard

CC Number: _____ Expiration Date: _____ Amount: _____

Cardholder Name: _____ Signature: _____