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 126
Fax: 310-424-3398
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 degree (MD, PhD or equivalent), board certified or eligible for board certification by a member board of the American Board of Medical Specialties (or its equivalent) with evidence of active membership in regional and national specialty societies. (USA and Canada)
I have been in practice since Year: _________. (Membership Dues: $300 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 with special clinical experience in field related to skull base surgery, outside USA or Canada. **I have been in practice since Year: _________**. (Membership Dues: $200 USD annually).
___ Yes, I want to receive the journal – (Journal Subscription: $100 USD annually).

☐ **CANDIDATE** – I am a resident or fellow in good standing in any board-approved residency/fellowship program, demonstrated a special interest and evolving experience in scientific endeavors related to the skull base.
Year Residency Complete: ________ Year Fellowship Complete: ______. (No annual membership dues).
___ Yes, I do wish to receive the journal – (Journal Subscription: $100 USD annually).

☐ **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: $125 USD annually).
___ Yes, I do wish to receive the journal – (Journal Subscription: $100 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 | Year Started | Year Completed

____
Residency: Institution | Year Started | Year Completed/To Be Completed | Areas of Specialization

____
Fellowship: Institution | Year Started | Year 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: One (1) Active NASBS members
INTERNATIONAL APPLICANT: One (1) Active member from ANY International Society
CANDIDATE APPLICANT: Residents/Fellows: One (1) Active NASBS members and a letter of good standing from Program Director
AFFILIATE: One (1) Active NASBS members *or* one (1) Affiliate NASBS member

____
Name (PLEASE PRINT) **Location**

____
Phone **Email Address**

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: _________CVV:______Amount: _____________

Cardholder Name: _________________________ Signature: ________________________________