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 (**NP, 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 ☐ NP ☐ RN ☐ LPN ☐ PA ☐ Other Degrees: _____

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

Gender: ☐ Male ☐ Female

PROFESSIONAL ADDRESS:

_____

(Association or Institution)

_____

(Department)

_____

(Street Address)

_____

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

_____

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

_____

(Assistant Name) (Assistant Phone Number) (Assistant E-Mail Address)

HOME ADDRESS:

_____

(Street Address)

_____

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

_____

(Cell-phone Number) (Fax Number) (Personal E-Mail Address)

MEDICAL EDUCATION:

_____

Undergraduate School: Institution Year Completed Degree

_____

Post-graduate School: Institution Year Completed Degree

_____

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: _____

WHICH COMMITTEE WOULD LIKE TO PARTICIPATE IN?

- ☐ Awards
- ☐ Membership & Credentials
- ☐ Scientific Program
- ☐ None
- ☐ Constitution & Bylaws
- ☐ Nominating
- ☐ Vendor Relations
- ☐ Finance & Audit
- ☐ Research
- ☐ Website & Publications

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: _____