



**PEDIATRIC ORTHOPAEDIC SOCIETY
OF NORTH AMERICA**
APPLICATION FOR CANDIDATE-ASSOCIATE MEMBERSHIP
Deadline: December 1

Check which level of Candidate Membership for which you are applying:

- Orthopaedic Resident *
 Pediatric Orthopaedic Fellow*
 Researcher

**An individual may apply for candidate-associate membership during residency training by providing confirmation of acceptance into a Pediatric Orthopedic Fellowship. For current Pediatric Orthopaedic Fellows, a letter from your Fellowship Director is required.*

About Yourself

Name: _____

Home Address: _____

City, State & Zip Code: _____

Home Phone: _____

Date of Birth: _____ Birthplace: _____ Citizenship: _____

Spouse's Name (optional): _____

Office Address: _____

City, State & Zip Code: _____

Office Phone: _____

Fax: _____ E-Mail: _____

Specify address to which mail is to be directed: office _home

Education

MEDICAL COLLEGE

Institution: _____ Degree: _____ Date: _____

City/State/Country: _____

RESIDENCY PROGRAM

Location	Chairperson	Dates
_____	_____	_____
_____	_____	_____

POST-RESIDENCY PEDIATRIC ORTHOPAEDIC EDUCATION

Location	Program Director	Dates
_____	_____	_____
_____	_____	_____

OTHER POST-GRADUATE STUDIES

Location	Program Director	Dates
_____	_____	_____
_____	_____	_____

Licensed to practice in the following States or Countries: (give dates)

Have you ever had your license revoked or restricted in any way? YES NO

Have you ever lost your privileges to practice at a hospital? YES NO

If yes, explain on a separate sheet.

ACADEMIC APPOINTMENTS

Institution	Academic Title
_____	_____
_____	_____
_____	_____
_____	_____

Please list all Hospitals with which you have privileges:

Institution

Location/Date

Teaching Affiliations:

Date/year you are scheduled to take Part II of ABOS exam _____

Date/year you are scheduled to complete the Canadian Royal College of Physicians & Surgeons Fellowship exam. _____

Date/year you are scheduled to complete the AOBOS Exam _____

Please list your subspecialty interests (i.e. hand, sports, spine, hip, neuromuscular, tumor, foot, UE, etc.)

Primary _____ Secondary _____

ADDITIONAL DATA (Attach a separate sheet if additional space is required)

Contributions To Medical Literature:

Other Scientific Contributions:

Medical Society Memberships: (List any office or committee appointment you hold or have held)

Academic Degrees other than M.D., D.O., Ph.D. and Special Honors:

PLEASE DESCRIBE IN PARAGRAPH FORM THE NATURE OF YOUR CURRENT PRACTICE AND HOW MUCH OF YOUR PROFESSIONAL ACTIVITY IS DEDICATED TO PEDIATRIC ORTHOPAEDICS. (Attach a separate sheet)

Sponsors

Sponsors **MUST** be **POSNA members** from the following: (Only one of which can be a practice associate)

- a.) Pediatric Orthopaedic Fellowship Director (If applicable)
- b.) A POSNA member in the applicant's locale
- c.) Another member of POSNA

Sponsors should upload their Sponsor Form and/or letter of recommendation via the online application site.

Compliance with By-Laws and Agreement of Confidentiality Regarding Application

The undersigned agrees that he/she will comply with each and every provision of the By-Laws of the Pediatric Orthopaedic Society of North America and any duly adopted rules and regulations pursuant thereto.

It is specifically agreed by the undersigned that in consideration of the Pediatric Orthopaedic Society of North America's treatment of the entire contents of this application, as well as inquiries or investigations made pursuant thereto as privileged and confidential material, and not subject to publication or public dissemination whether voluntary, involuntary, or operation of law; that the undersigned specifically authorizes the Pediatric Orthopaedic Society of North America to make whatever inquiries or investigations it deems necessary to verify the credentials, professional standing, and moral and/or ethical character of the undersigned. The undersigned further agrees that he/she will not cause or attempt to cause any public disclosure of the contents of any application for membership in the Pediatric Orthopaedic Society of North America or any proceedings of the Membership Committee or the Board of Directors pursuant thereto whether said public disclosure be by operation or law or otherwise.

Name _____ Date _____

By checking this box you are indicating that you have read the above and agree to it.

POSNA is managed by AAOS Society Management Services. In their role for your society, an AAOS employee will be handling your data.