# PEDIATRIC ORTHOPAEDIC SOCIETY OF NORTH AMERICA

## APPLICATION FOR CANDIDATE-CORRESPONDING MEMBERSHIP

**Deadline: December 1**

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

- ☐ Orthopaedic Resident *
- ☐ Pediatric Orthopaedic Fellow*
- ☐ Pediatic Orthopaedic Surgeon, pre-Board Certified

**An individual may apply for candidate-corresponding 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 your Certification Exam: _____ OR Year Certified: _____

Certifying Organization:_____

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

Primary _____ Secondary _____

**ADDITONAL 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. and Special Honors:

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**PLEASE DESCRIBE IN PARAGRAPH FORM, THE NATURE OF YOUR CURRENT PRACTICE AND PROVIDE EVIDENCE THAT AT LEAST FIFTY PERCENT OF YOUR PROFESSIONAL ACTIVITY IS DEDICATED TO PEDIATRIC ORTHOPAEDICS**.

**Sponsors**

Sponsors should be from the following: (Only one of which can be a practice associate)

a.) Pediatric Orthopaedic Fellowship Director (If applicable)
b.) A POSNA member familiar with your practice
c.) A practicing pediatric orthopaedic surgeon from your country

*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.

Nane _____ 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.**