PEDIATRIC ORTHOPAEDIC SOCIETY OF NORTH AMERICA

APPLICATION FOR CANDIDATE-ASSOCIATE MEMBERSHIP

***ALL APPLICATIONS DUE December 1**

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

- ☐ Orthopaedic Resident *
- ☐ Pediatric Orthopaedic Fellow
- ☐ Researcher

To be eligible for Candidate-Associate Membership you must have fulfilled all of the following:

- **Successful completion of an approved ACGME Orthopaedic Residency;****
- **Actively engaging in the practice of medicine and devoting at least fifty percent of professional time to Pediatric Orthopaedics;**
- **Living and practicing medicine in the United States or Canada.**

***If you are an orthopedic surgery resident, you must attach a letter from your US or Canadian pediatric orthopedic surgery fellowship director verifying your appointment.**

About Yourself

Name:_____

Home Address:_____

City, State, Zip:_____

Home Phone:_____

Date of Birth:_____ Birthplace:_____ Citizenship:_____

Spouse's Name (optional): _____

Office Address:_____

City, State, Zip:_____

Office Phone: _____

Fax: _____ E-Mail: _____

Specify address to which mail is to be directed: ☐ office ☐ home

About Your Education

MEDICAL COLLEGE

Institution:_____ Degree:_____ Date:_____

City/State/Country:_____

RESIDENCY PROGRAM NAME

Location	**Chairperson**	**Dates**

POST-RESIDENCY PEDIATRIC ORTHOPAEDIC EDUCATION

Location	**Program Director**	**Dates**

OTHER POST-GRADUATE STUDIES

Location	**Program Director**	**Dates**

CONTRIBUTIONS TO MEDICAL LITERATURE:

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)

About Your Current Work

Please list all hospitals with which you have privileges:

Institution	**Location**

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**

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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.

Name and Address of Sponsors

The Membership Sponsor Form should be sent to three sponsors who must fill out the form and unload it to the applicant's online application. Provide your sponsors with the **Membership Sponsor Form.** Each sponsor must be an Acitve or Senior Member of POSNA.
At least **ONE** sponsor must be familiar with the nature of your clinical practice. If appropriate, include the Fellowship Director.

1. Name:_____

Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____

2. Name:_____

Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____

3. Name:_____

Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____

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.**