AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS

5550 Meadowbrook Industrial Court
Rolling Meadows, Illinois 60008
Phone: 847/378-0500
Toll free: 888-566-AANS

CANDIDATE/RESIDENT MEMBER APPLICATION

****NORTH AMERICAN RESIDENTS ONLY****

SECTION I – PERSONAL INFORMATION

Name (in full): _____
First M. Last Suffix Degree

Preferred Mailing Address: _____
(please check one) Street Apt.#/Suite #/Room #
❑ Business
❑ Home
_____
City State/Zip or Postal Code Country

Business Phone: (_____) _____ Cell Phone: (_____) _____
Area Code Area Code

Fax Number: (_____) _____ Date of Birth: _____ NPI #: _____
Area Code

E-mail Address*: _____

Please keep me informed with emails regarding:

☐ AANS/CNS Sections ☐ Annual Meeting ☐ Educational Resources ☐ NREF Grants ☐ NeuroPoint Data ☐ News & Updates

SECTION IIA US & CANADA ONLY– PROFESSIONAL EDUCATION/NEUROSURGICAL TRAINING

NEUROSURGICAL RESIDENCY TRAINING

Institution: Start Date: Expected End Date:

_____ _____ / _____ to _____ / _____
month year month year

Please check one: ❑ PGY-1 ❑ PGY-2 ❑ Other: PGY- ___

YOUR PROGRAM DIRECTOR MUST SIGN THE FOLLOWING STATEMENT:
I certify that the doctor named on this form is a resident enrolled in a neurosurgical residency training program approved by the Accreditation Council for Graduate Medical Education, The Royal College of Physicians and Surgeons (Neurosurgery) of Canada, The Mexican Council of Neurological Surgery, A.C., or an AOA-approved OGME neurosurgical residency program.

_____ _____
Program Director (Please Print) Program Director Signature

Please continue onto page 2.

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SECTION IIB MEXICO ONLY– PROFESSIONAL EDUCATION/NEUROSURGICAL TRAINING

NEUROSURGICAL RESIDENCY TRAINING

Institution (please check only one):

- ❑ Instituto Nacional de Neurologia y Neurocirugia
- ❑ Nuevo Leon State University
- ❑ Unidad Medica de Alta Especialidad IMSS-Guadalajara
- ❑ Other (please specify): _____

Start Date: Expected End Date:

_____ / _____ to _____ / _____
month year month year

YOUR PROGRAM DIRECTOR MUST SIGN THE FOLLOWING STATEMENT:

I certify that the doctor named on this form is a resident enrolled in a neurosurgical residency training program approved by The Mexican Council of Neurological Surgery, A.C.

_____ _____

Program Director (Please Print) Program Director Signature

SECTION III – CERTIFICATION

I hereby certify that, to the best of my knowledge, the information I provided on this form is true and complete.

_____ _____

Signature Date

Please email completed form to memberservices@aans.org.