International PhD/Post-Doctoral (in-training) Membership Application

RETURN THIS APPLICATION, YOUR CV & PROGRAM VERIFICATION LETTER VIA MAIL, FAX OR EMAIL (PDF) TO:

AAAAI Senior Membership Manager, 555 E. Wells Street, Suite 1100 • Milwaukee, Wisconsin 53202-3823

Phone: (414) 272-6071 • Fax: (414) 272-6070 • E-mail: membership@aaaai.org • Website: www.aaaai.org

First Name: ______________________________

Last (*Family*) Name: ______________________________

Ethnicity: ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Caucasian

National Provider Identifier (NPI): ______________________________

Preferred Email: ______________________________

Date of Birth: _______ / _______ / 19 _______
Month Day Year

☐ MD ☐ DO ☐ PhD ☐ _______________

Gender: ☐ Male ☐ Female

Address Information **Preferred mailing address:** ☐ **Home** ☐ **Program/School**

Home Address: ______________________________

City: ____________________ State: __________ Zip: __________ Country: ____________

Phone: ______________________________

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Program/School Name: ______________________________

Program Street Address: ______________________________

City: ____________________ State: __________ Zip: __________ Country: ____________

Phone: ____________________ Start Date: __________ Anticipated Completion Date (required): __________

Program Type: ☐ Allergy/Immunology ☐ Other: ______________________________

Training & Education Information

Undergraduate School Name: ______________________________ Country: ____________

Area of Study: ____________________ Start Year: __________ End Year: __________

Graduate School Name: ______________________________ Country: ____________

Area of Study: ____________________ Start Year: __________ End Year: __________

Postgraduate School Name: ______________________________ Country: ____________

Area of Study: ____________________ Start Year: __________ End Year: __________

Medical School Name: ______________________________ Country: ____________

Medical Education: ☐ MD ☐ PhD ☐ DO Start Year: __________ End Year: __________

Residency School Name: ______________________________ Country: ____________

Type: ☐ Int. Medicine ☐ Pediatrics ☐ Other: ____________Start Year: __________ End Year: __________

Fellowship School Name (other than above): ______________________________ Country: ____________

Area of Study: ____________________ Start Year: __________ End Year: __________

Certification Information

I am Board Certified in: ☐ Internal Medicine (Date: ____________) ☐ Pediatrics (Date: ____________)

☐ Other: ______________________________ (Date: ____________)

☐ Other: ______________________________ (Date: ____________)