



AMERICAN ACADEMY OF ALLERGY  
ASTHMA & IMMUNOLOGY

**AAAAI In-Training Member Application Form**

Return this form with a **copy of your current CV** and a **letter from your Program Director verifying your fellowship training** to Membership Services, via fax (414) 272-6070 or by mail. If you have any questions, please call Membership Services at (414) 272-6071 or e-mail membership@aaaai.org

**TO BE FILLED OUT BY CURRENT FELLOW-IN-TRAINING**

Please print clearly

Name (include MD, DO, etc.): \_\_\_\_\_

Do you hold a fellowship slot in an ACGME-approved allergy/immunology training program?  YES  NO

Upon finishing your program, will you be ABAI-eligible?  YES  NO

Mailing Address: Place a check next to your preferred mailing address

Office Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

**DEMOGRAPHICS (optional)** Gender:  Male  Female Race:  African American  Asian  Caucasian  Hispanic  Native American  Other \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / 19\_\_\_\_

**FELLOWSHIP TRAINING**

Program or Institution: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Program Type:  Allergy/Immunology  Other: \_\_\_\_\_

Program Start Date: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

Name of Program Director: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE SIGNED BY APPLICANT'S PROGRAM DIRECTOR**

**EDUCATION AND TRAINING**

Undergraduate (Degree, location, year): \_\_\_\_\_

Medical Education (Degree, location, year): \_\_\_\_\_

Residency (Degree, location, year): \_\_\_\_\_

Certifications (ABIM 2004, ABP 2005, etc): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN APPLICATION WITH CV & PROGRAM DIRECTOR LETTER**

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