



# International Fellow-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](mailto:membership@aaaai.org) • Website: [www.aaaai.org](http://www.aaaai.org)

First Name: _____ Last (Family) Name: _____ Ethnicity: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Caucasian National Provider Identifier (NPI): _____ Preferred Email: _____	Date of Birth: _____ / _____ / 19_____ <small style="margin-left: 100px;">Month      Day      Year</small> <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PhD <input type="checkbox"/> _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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**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: <input type="checkbox"/> Allergy/Immunology <input type="checkbox"/> 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: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> DO	Start Year: _____	End Year: _____

Residency School Name: _____		Country: _____
Type: <input type="checkbox"/> Int. Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> 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: <input type="checkbox"/> Internal Medicine (Date: _____)	<input type="checkbox"/> Pediatrics (Date: _____)
<input type="checkbox"/> Other: _____ (Date: _____)	<input type="checkbox"/> Other: _____ (Date: _____)