



American  
Association of  
Neurological  
Surgeons

## MEDICAL STUDENT MEMBER APPLICATION

Medical students in accredited allopathic or osteopathic medical schools in the United States, Canada, and Mexico are eligible to apply for AANS Medical Student membership. Membership will expire upon graduation from medical school unless the student enters an approved neurosurgical residency and membership is converted to Candidate category.

Please type or clearly print information except where signatures are required.

### SECTION I - CONTACT INFORMATION

Name (in full): \_\_\_\_\_  
First M Last Suffix

Preferred Mailing Address: \_\_\_\_\_  
Street Apt#/Room#

Home \_\_\_\_\_  
 Business \_\_\_\_\_  
City State Zip Code Country

Phone Number: \_\_\_\_\_  
Cell Phone

Date of Birth: \_\_\_\_\_  
Date of Birth

\*Email Address \_\_\_\_\_  
Email

Please keep me informed with emails regarding:

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

**\*AANS DOES NOT SELL EMAIL ADDRESSES**

### SECTION II - MEDICAL SCHOOL INFORMATION

Institution: (Full name-no acronyms) \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_  
month / year to month / year

### **YOUR DEAN OF STUDENTS OR MEDICAL DIRECTOR MUST SIGN THE FOLLOWING STATEMENT:**

I certify that the student named on this application is currently enrolled in our medical school and that the start and end dates above are correct.

\_\_\_\_\_  
 Title (Dean or Medical Director) Name (please print)

\_\_\_\_\_  
 Dean/Medical Director Signature Dean/Medical Director E-mail

### SECTION III - APPLICATION FEE

There is an application fee of \$25.00 US for this AANS membership category.

American Express    Discover    MasterCard    VISA    Check (Payable to the American Association of Neurological Surgeons)

I belong to the \_\_\_\_\_ AANS Medical Student Chapter. Upon verification, my AANS Medical Student application fee will be waived and credit card not processed/check returned.

Name on Card: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Card Security/Verification Code: \_\_\_\_\_

\_\_\_\_\_  
 Billing Address

\_\_\_\_\_  
 Applicant's Signature

\_\_\_\_\_  
 Date

**Mail payment and completed form to:**  
American Association of Neurological Surgeons  
Attn: Member Services  
5550 Meadowbrook Drive  
Rolling Meadows, IL 60008

**Or e-mail to:** [memberservices@aans.org](mailto:memberservices@aans.org)

**If e-mailing and paying by check, application will not be processed until application fee is received**

**For questions, call or e-mail:**  
AANS Member Services at 847.378.0500 or  
[memberservices@aans.org](mailto:memberservices@aans.org)