

# AMERICAN ASSOCIATION OF NEUROLOGICAL SURGEONS



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

## CANDIDATE/FELLOW MEMBER APPLICATION

### 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 II – PROFESSIONAL EDUCATION/NEUROSURGICAL TRAINING/FELLOWSHIP

#### FELLOWSHIP TRAINING PROGRAM (RESEARCH FELLOWS ARE NOT ELIGIBLE)

Institution \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_  
month / year to month / year

Fellowship Subspecialty: \_\_\_\_\_

Medical Specialty (if you did not complete a neurosurgical residency): \_\_\_\_\_

### YOUR FELLOWSHIP DIRECTOR MUST SIGN THE FOLLOWING STATEMENT:

I certify that the doctor named on this application is enrolled in a neurosurgical training program approved by the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons (Neurosurgery) of Canada or the Mexican Council of Neurological Surgery, A.C. and is in a clinical neurosurgical fellowship performing surgery and seeing patients.

\_\_\_\_\_  
Fellowship Director (Please Print)

\_\_\_\_\_  
Fellowship Director Signature

### SECTION III – CERTIFICATION

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

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

Please email completed form to [memberservices@aans.org](mailto:memberservices@aans.org).