

AANS American Association of Neurological Surgeons

CANDIDATE/FELLOW MEMBER APPLICATION

Name (in full): _____

First	M.	Last	Suffix	Degree

City	State/Zip or Postal Code	Country
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E-mail Address*: _____

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Institution	Start Date	End Date
	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> _____ <small>month</small> </div> <div style="text-align: center;">/</div> <div style="text-align: center;"> _____ <small>year</small> </div> </div>	<div style="display: flex; justify-content: space-between; align-items: center;"> <div style="text-align: center;"> _____ <small>month</small> </div> <div style="text-align: center;">/</div> <div style="text-align: center;"> _____ <small>year</small> </div> </div>

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

Fellowship Director Signature

Signature: _____ Date: _____

Please email completed form to memberservices@aaans.org.