Houston Society of Otolaryngology-Head and Neck Surgery

John P. McGovern Bldg.
1515 Hermann Drive
Houston, Texas 77004

Date: _____

Application for Membership

Type: ( ) Full ( ) Associate-Residents/Fellows

Name in Full: _____ Degree: _____

Office Address: _____ City: _____ State: _____ Zip: _____

Ph: _____ Fax: _____ Email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Medical Education & Date of Graduation: _____

Graduate Training:

Internship: _____

Residency: _____

Fellowship: _____

Board Certification & Date: _____

Practice Limited to: _____

Endorsed by: (2 regular members required)

1. _____ 2. _____

I hereby apply for membership to the Houston Society of Otolaryngology-Head and Neck Surgery, and if elected, agree to abide by its constitutions and bylaws. I am a member of good standing at the _____ County Medical Society and the Texas Medical Association. I certify that to the best of my knowledge, all of the above information is true and correct.

_____ **Date: _____**
Applicant's Signature

Annual Membership Dues: $195.00
******Associate-Resident/Fellows are guest of the Society.

Please Remit to: Houston Society of Otolaryngology Administration Office (address above)
Or Fax: (713) 526-1434 Email: Kristelle_Grant@hcms.org

Office Use Only:
Type of Membership: ( ) Associate-Resident/Fellows ( ) Regular ( ) Emeritus

Society Vote: ( ) Accept ( ) Reject **Date: _____**