MEMBER DUES INVOICE

1844 Ardmore Blvd.
Pittsburgh, PA 15221

Phone: (412) 243-5156
Fax: (412) 243-5160

Description	*Amount*
Membership Investment-PRIMARY MEMBER	$345.00

PLEASE COMPLETE THE QUESTIONS ON THE BACK SIDE OF THE INVOICE!

PAYMENT Options are on the back of this form. If paying by check submit payment to -

AOA
1844 Ardmore Blvd.
Pittsburgh,PA 15221

Membership Dues Include -
* Member only access on the website, www.oto-online.org
* Member pricing for the Annual Meeting
* Member pricing for the AOA's Clinical support Staff Manual
* Website discussion boards specific to ENT
* Subscription to Oto-Scope
* Subscription to monthly electronic newsletter
* Access to legislative advocacy important to ENT
* ENT specific Salary and Benchmarking Surveys
* Networking with other Otolaryngology Administrators

Sub Total	$345.00
Tax	$0.00
Total	$345.00
Paid	$0.00
AMOUNT DUE	$345.00

Name: ____

You are important to us! Please take the time to complete the below questions and return this side of the form with your dues!!!!
(Please indicate any changes to your demographic data here)

Address: ____

Address: ____

City, State, Zip: ______________________________________

Phone: _____________________Fax: _____________________

Email: ____

Number of FTE Physicians __________ Number of FTE Non-Physicians ____________

☐ **I authorize the AOA to contact me via email or fax**

Practice Type (please check one):

☐ Private Practice
☐ Academic
☐ Owned by PPMC
☐ Vendor

Practice Info (check all that apply to your practice):

☐ OTO-HNS
☐ Facial Plastics
☐ Clinical Research
☐ SET/IDT
☐ ACS
☐ ABR/ENG
☐ Hearing Aids
☐ Voice Center
☐ Certified Coder
☐ Neuro/Otology
☐ Pediatrics only
☐ RAST
☐ CT Scanner
☐ Vestibular Rehab
☐ NP/PA
☐ Sleep Center
☐ EMR

I have knowledge and/or experience in the following areas (check all that apply):

☐ Website Development
☐ Policy/Procedure Development
☐ Marketing/Advertising
☐ Public Speaking
☐ CPT/ICD9 Coding
☐ Journalism/Publishing
☐ Legislative Activities

Name of Managing Physician: ______________________________

Physician AAO-HNS Member#______________

PAYMENT OPTIONS: Paying by credit card? Complete and fax to 412-243-5160.

Credit Card payment type: ☐ MasterCard ☐ Visa ☐AMEX

I authorize the AOA to charge $_____ to the credit card below:

Cardholder's Name print /signature ____

Credit Card number ____

Expiration Date __________________ Billing zip code of cardholder_________________

CID number (the last three numbers on the back of card) __________

Check payment: If paying by check see front for mailing address of lockbox

Your name will be removed as a member of AOA as of January 31 unless renewed.