Virginia Neurological Society

Established 1972
Web address: http://vns.aan.com

APPLICATION FOR MEMBERSHIP

1. **Please print or type**
2. **Answer all questions**
3. **A letter of recommendation from a current Active member is required.**
4. **A curriculum vitae *must* be appended to this application.**

Name:_____
Last First Middle

Business Address:_____
Street or P.O. Box

_____
City State Zip Code

Business Phone: ( ) _____ Fax # :( ) _____E-mail: _____

Home Address:_____
Street or P.O. Box

_____
City State Zip Code

CATEGORIES OF MEMBERSHIP: *Please note that Categories A, B and C must be medical doctors, primarily engaged in the science of Medical Neurology, including practice, teaching, research or community service.*
*Only **Category A** members may vote or hold office.*

A. **ACTIVE MEMBER:** Primarily engaged in the science of medical neurology, including practice, teaching, research or community development.
B. **ASSOCIATE MEMBER:** Postdoctoral individuals in allied fields having a special interest in neurological science. Ordinarily these members are doctors of medicine, philosophy or science.
C. **JUNIOR MEMBER:** Graduate medical doctors still in training in neurological sciences.

Category of membership for this application: _____

1. (a) Are you certified in neurology by the American Board of Psychiatry and Neurology? ☐ Yes ☐ No

(b) If your answer to l. (a) is "yes", please state your certificate number _____
and date of certification _____

(c) If your answer to 1. (a) is "no", are you Board eligible? _____
When will you take the examination? _____

2. Are you certified in any other specialty? ☐ Yes ☐ No
If "yes", what specialty? _____

3. In what state(s) are you currently licensed to practice medicine?
_____

4. Year license issued _____ License expiration date _____
Has your license to practice medicine ever been revoked by any state? ☐ Yes ☐ No
Have your privileges at any hospital ever been suspended or revoked? ☐ Yes ☐ No
If either is "yes", then append details on a separate page.

5. Number of years in practice in Virginia: _____

6. Education: (Location and year(s)

M.D._____
Residency_____
Fellowship _____

7. Teaching Positions: (Faculty Title, Hospital, Location)

_____

_____

_____

8. Practice Setting:
_____ Solo Private Practice
_____ Group Private Practice
_____ Multi-Specialty Private Practice
_____ Academic Institution Name:_____
_____ Military

9. Your date of birth: _____
month day year

10. Place of birth: _____

I authorize the officers and/or administrator of the Virginia Neurological Society to contact any person or institution or government agency and to have released to the Virginia Neurological Society any information pertinent to verification of statements I have made in this application and attached curriculum vitae, and to solicit any additional information pertinent to a determination of my professional qualifications and my moral and ethical character.

_____ _____
Signature Date

Your membership dues will be waived for your first year of membership. Approval of membership takes place during the VNS Annual meeting, which begins Thursday of the first week-end in February at The Homestead.

Please return your completed application and curriculum vitae to:

Pamela M. Mazmanian, Administrator
Virginia Neurological Society
P.O. Box 29274 * * * Richmond VA 23242-0274
Phone and Fax: (804) 741-7179 * * * E-mail: pammaz@verizon.net