AAISG

2023 Membership Application

Date: _____

Applicant Information

Full Name	
Email	
Phone	
Fax	
Date of Birth	

Medical Societies

AAAAI *American Academy of Allergy, Asthma & Immunology*	Year(s) Member _____ Fellow _____
ACAAI American College of Allergy, Asthma & Immunology	Year(s) Member _____ Fellow _____
Other Societies	

Professional Status

Patient Type(s)	☐ Pediatric ☐ Adult		
Accepting New Patients?	☐ Yes ☐ No		
% Of practice limited to allergy		Years in practice of allergy	
Diplomate American Board Certifications	Year ☐ Allergy & Immunology _____ ☐ Internal Medicine _____ ☐ Pediatrics _____		
Hospital Affiliation(s)			
Publications (Please attach bibliography)			

Education & Training

Medical School	
Graduation Date	
Internship & Residency	
Allergy Fellowship Training	
Name of Program Director	

2023 membership dues are $150 and can be paid via check or online via our secure payment portal. Please visit www.aaisg.org for more information on membership dues or to pay online.

Please email this completed form to: dfirschein@allergypartners.com

For AAISG Use Only

Application mailed: _____/_____/_____

Application received: _____/_____/_____

Executive committee review date: _____/_____/_____

Execute Committee recommendation: _____

Date of Notification to applicant: _____/_____/_____