



**Application for Membership**  
**West Virginia Academy of Otolaryngology - Head and Neck Surgery, Inc.**

Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City, State, ZIP Code: \_\_\_\_\_

Telephone No. (\_\_\_\_) \_\_\_\_\_ Fax No. (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Undergraduate School: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

Medical School: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

Degree: \_\_\_\_\_

Residency: \_\_\_\_\_

Fellowship: \_\_\_\_\_

Are you:

Certified by the American Board of Otolaryngology?    ☐ Yes    ☐ No    Year: \_\_\_\_\_

Fellow in AAO-HNS?    ☐ Yes    ☐ No    Year: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return this application, with a \$225 check made payable to WVAO-HNS, Inc., to:**  
F. Thomas Sporck, M.D., F.A.C.S. Secretary-Treasurer  
WVAO-HNS  
Post Office Box 11306  
Charleston, WV 25339-1306

