North Pacific Orthopaedic Society

MEMBERSHIP APPLICATION

Please complete both sides of the following application and return to the NPOS office with your annual dues payment made payable to NPOS. Dues are based on anniversary year.

Please select your membership type:

☐ **Active (Individual) - $200**: Physician in good standing with governing licensing board and in active practice as an orthopedic surgeon. Active members may hold elective office and vote.

Required - Active License Information: State_____ License #: _____

Qualifications for Active Membership:

- Certification or board eligible by the American Board of Orthopedic Surgery or has qualified for Fellowship in The Royal College of Surgeons of Canada or be certified by the American Osteopathic Board of Orthopedic Surgery.
- High ethical standing in the orthopaedic community.

☐ **Additional Active (Individual) - $100:** Additional physician in good standing with the governing licensing board from the same practice or organization as one other active member. The same requirements above are required for physician(s) applying through this designation.

☐ **Corporate (Practice/Organization) - $500:** Practices/organizations with two (2) or more orthopaedic surgeons qualify for this membership type (suggested for locations with more than five (5) physicians). All physicians must adhere to the requirements as described in Active membership above. Membership benefits and pricing are extended to all orthopaedic surgeons and non-surgical associates at the organization/location though only one vote is allowed per corporate member.

☐ **Allied Health - $100***: Surgical and non-surgical associates such as PAs, RNs, physical and occupational therapists, and other professionals who directly support member orthopaedic surgeons. Allied Health membership applications must include an active member as a sponsor. Allied Health members shall not have voting rights except when voting for their board of directors representative, but shall be entitled to all other membership benefits.

**Discounted memberships are available for additional/multiple Allied Health memberships from the same company:* *First member=$100, Second member=$75, Third or more=$50 per member*

To qualify as an additional member, please list the first member's name here: _____

APPLICANT INFORMATION

If applying for Corporate membership, this individual should be the Primary Designated Member (with voting rights).

Full Name (Include First, Middle, Last, and All Degrees/Designations/Suffixes – i.e.: MD, FACS, Jr., etc.)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. _____

Profile/Directory Address *(This is how you appear to others and in listings for association business.)*

Practice/Company Name *(if applicable)*:_____

Address *(include Dept./Mail Stop)*:_____

City:_____ **State**: _____ **Zip Code**:_____

Mailing Address *(Information/renewals, etc. will be sent here)*

☐ Same as Profile/Directory info above

Practice/Company Name *(if applicable)*:_____

Address *(include Dept./Mail Stop)*:_____

City:_____ **State**: _____ **Zip Code**:_____

County: _____

PLEASE COMPLETE 2ND PAGE ⇨

North Pacific Orthopaedic Society | 147 SE 102nd Avenue - Portland, Oregon 97216
Phone: 503.445.6691 | Toll Free: 866.903.NPOS (6767) | Fax: 503.253.9172
Email: info@northpacificortho.org | Website: www.northpacificortho.org
Tax ID #: 93-0829638 Revised October 2016

Home Address *(This will not be published anywhere or provided to anyone.)*

Address:_____

City:_____ State: _____ Zip Code:_____

Contact Information *(Corporate members-this information should be for Primary Member)*

Business/Daytime Phone: _____ Cell Phone: _____

Toll Free Phone: _____ Fax: _____

Primary Email:_____

Secondary/Alternate Email: _____Website:_____

Home Phone: _____ Home Fax: _____

Spouse Name:_____Spouse Email:_____

Office/Administrative Contact – REQUIRED for all Membership Types

This person is (circle one): Office Manager | Assistant | Nurse | PA | Other:_____

Name:_____Position Title:_____

Email:_____

Office Backline:_____Fax:_____

ACTIVE - AREAS OF SPECIALTY: Please check *all* orthopaedic areas of specialty in your current practice:

- ☐ Administration
- ☐ Arthroscopic Surgery
- ☐ Foot/Ankle Reconstruction
- ☐ General Orthopedics
- ☐ Hand/Upper Extremity Surgery
- ☐ Hip/Knee Reconstruction
- ☐ Knee Reconstruction
- ☐ Medicolegal IME Consulting
- ☐ Office Orthopedics Only
- ☐ Orthopaedic Hospitalist Practice
- ☐ Orthopaedic Oncology
- ☐ Orthopaedic Trauma Surgery
- ☐ ☐ Pediatric Orthopedics
- ☐ ☐ Shoulder Reconstruction
- ☐ ☐ Spine Surgery
- ☐ ☐ Sports Medicine/Surgery
- ☐ ☐ Other: _____
- ☐

Who can we thank for referring you to NPOS? *(optional)*_____

Attention Corporate Members

Please list all individual member representatives for your company/practice on the next page. You may add/update this information at any time by sending an email to info@northpacificortho.org.

PAYMENT OPTIONS: ☐ Check (payable to NPOS) ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

For credit card payments, complete all fields below. ***Fax both pages of this form to 503.253.9172.***

Card Number:_____Exp. Date:_____

Name on Card:_____$ Authorized:_____

Card Billing Address:_____City:_____ State:___ Zip:_____

Signature:_____

Email Receipt To:_____

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NPOS Corporate Members – Designated Representatives

Please provide all designated member representative's information from your company/practice here. The primary member representative should be listed on page 1 of this application. Include as many individuals as you have. You may add/update this information at any time by sending an email to info@northpacificortho.org. All other information for these representatives will be listed as provided in the company/practice section.

Full Name ______________________________
(Include First, Middle, Last, and All Degrees/Designations/Suffixes – i.e.: MD, FACS, Jr., etc.)

Email:______________________________Backline:______________________________

Office Contact/Nurse:______________________________Email:______________________________

☐-Physician* ☐-Non-Surgical Associate Area(s) of Specialty:______________________________

*Active/physician members must have an Active License. State: ______________ License #:______________

Full Name ______________________________
(Include First, Middle, Last, and All Degrees/Designations/Suffixes – i.e.: MD, FACS, Jr., etc.)

Email:______________________________Backline:______________________________

Office Contact/Nurse:______________________________Email:______________________________

☐-Physician* ☐-Non-Surgical Associate Area(s) of Specialty:______________________________

*Active/physician members must have an Active License. State: ______________ License #:______________

Full Name ______________________________
(Include First, Middle, Last, and All Degrees/Designations/Suffixes – i.e.: MD, FACS, Jr., etc.)

Email:______________________________Backline:______________________________

Office Contact/Nurse:______________________________Email:______________________________

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Full Name ______________________________
(Include First, Middle, Last, and All Degrees/Designations/Suffixes – i.e.: MD, FACS, Jr., etc.)

Email:______________________________Backline:______________________________

Office Contact/Nurse:______________________________Email:______________________________

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Full Name ______________________________
(Include First, Middle, Last, and All Degrees/Designations/Suffixes – i.e.: MD, FACS, Jr., etc.)

Email:______________________________Backline:______________________________

Office Contact/Nurse:______________________________Email:______________________________

☐-Physician* ☐-Non-Surgical Associate Area(s) of Specialty:______________________________

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Copy this page to add additional individual member representatives. Send all completed pages to the NPOS office.

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