Southeastern Allergy, Asthma and Immunology Society
Application for Membership

FOR OFFICE USE ONLY

Amt Rcvd._____

Date Rcvd. _____

Please print or type:

Name: _____ Special Designations:_____

Office Address: _____

City: _____ State:_____ Zip:_____

Phone: (_____) _____ - _____.

Fax: (_____) _____ - _____. Email:_____

Your home address will be kept on file and **never** be published:

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:(_____) _____ - _____.

I wish to have mail sent to *(check one)*: ☐ Home ☐ Office

$100 fee required for membership.

Checks may be made out to: Southeastern Allergy, Asthma and Immunology Society

EDUCATION & TRAINING

Degree(s)	Name of University *(undergraduate)*	Location *(City)*	Year Graduated

Name of Medical School	Location *(City)*	Year Graduated
#1		
#2		

Name of Training Program		Specialty	Location *(City, St)*	Begin Year/End Year
Internship				
Residency #1				
Residency #2				
Allergy Fellowship (in approved training program)		N/A		
Additional Fellowship				

Certification:_____ Certificate #:_____ Date:_____

Certification:_____ Certificate #:_____ Date:_____

Certification:_____ Certificate #:_____ Date:_____

ABAI Recertification: ☐ No ☐ Yes ➢ Certificate #:_____ Date:_____

Please list two active Southeastern Allergy, Asthma & Immunology members for reference:

1. Name:_____ Phone:_____

2. Name:_____ Phone:_____

Signature:_____ Date:_____