Print Form

Orthopaedic Rehabilitation Association

Application for Membership

Name: Date of Birth:
Spouse's Name:
Office Address: Street Address:
City: State: Zip:
Phone: Fax: Email:

Home Address: Street Address:
City: State: Zip:
Phone: Fax: Email:

AAOS Member: Yes: No: Year:
Canadian Ortho Association Member: Yes: No: Year:
ABOS Member: Yes: No: Year:
Canadian FRCS-C Certified: Yes: No: Year:
Please list your orthopaedic interest(s)

Please identify the type of membership for which you are applying:

☐ Active Member: (full membership)

Name and address of one sponsor (sponsor must be an ORA member)
Sponsor:
Address:
City & State: Zip:

☐ Corresponding (Foreign) Member --- (Non-Voting)
Sponsor:
Address:
City & State: Zip:
You are responsible for contacting your sponsor to write the letter of recommendation

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☐ Resident Member: (non voting)
* No application fee or dues while engaged in a residency program.
Resident applications for membership must be submitted with a letter of recommendation from the chairperson of the residency program.

Signature: Date: