

# NORTHWEST ACADEMY OF OTOLARYNGOLOGY

## MEMBER PROFILE

### Member Information:

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

Title: \_\_\_\_\_ (e.g. MD, PhD, DO)

Medical School Attended and Year Graduated: \_\_\_\_\_

Residency and Year Completed: \_\_\_\_\_

Fellowship and Year Completed: \_\_\_\_\_

Board Certifications: \_\_\_\_\_

### Contact Information:

Primary Clinic Name: \_\_\_\_\_

Primary Clinic Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Business Phone: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

Clinic Website: \_\_\_\_\_

Other clinic location(s): \_\_\_\_\_

### Please Check Appropriately:

Private Practice     Group Practice     University Faculty     HMO

### Practice Information:

Please **circle** your practice specialty: (for referral purposes)

Audiology

Broncho-Esophagology

Facial Plastic Surgery

General Otolaryngology

Head & Neck Surgery

Laryngology

Maxillofacial Surgery

Neurotology

Otolaryngic Allergy

Otolaryngic Pathology

Otology

Pediatric Otolaryngology

Rhinology

Sleep Medicine

Please complete & return this form to:  
Northwest Academy of Otolaryngology  
Fax: (206) 441-5863 – Email: [smc@wsma.org](mailto:smc@wsma.org)