



# 2025 Membership Application and Dues Statement

Iowa Academy of Otolaryngology

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

**Please check the box that best describes you.**

- Active Membership -\$100.00  
(Physician who has a license to practice in Iowa, who meet educational standards reasonability equivalent to the requirements of the American Board of Otolaryngology.)
- Associate Membership -\$100.00  
(Persons in fields allied to otolaryngology who are not eligible for regular membership)
- Resident Membership – No Cost

**Total Payment \$** \_\_\_\_\_

**Payment Type:**

- Check** (payable to Iowa Academy of Otolaryngology)
- Credit Card:**     MasterCard     Visa     Discover     AMEX

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code (CVV) \_\_\_\_\_

Name of Card Holder (Printed) \_\_\_\_\_

Billing Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Signature \_\_\_\_\_

**To receive an invoice or if you have any questions, please contact:**

[gflaming@iowamedical.org](mailto:gflaming@iowamedical.org)

**Notice on Dues Deductibility:**

Dues may be deducted as an ordinary and necessary business expense.

**Return form to:**

**Iowa Academy of Otolaryngology  
515 E. Locust St. Ste 400  
Des Moines, IA 50309**

Internal IAO Use Only:
Check # _____
Date received _____