

**VISITING PROFESSORSHIP APPLICATION**  
**American Academy of Pediatrics**  
**Section on Allergy/Immunology**

**Name of institution & affiliation:** \_\_\_\_\_

**Name for contact:** \_\_\_\_\_ **Title/Position** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Estimated audience (number):**

**Residents/ Fellows:** \_\_\_\_\_ **Faculty/Attending Physicians** \_\_\_\_\_

**Medical students** \_\_\_\_\_ **Other** \_\_\_\_\_

**Please indicate 3-5 areas of strongest educational needs from among the following (may include any of the subcategories listed):**

\_\_\_\_\_ Allergic rhinoconjunctivitis

\_\_\_\_\_ Allergic rhinitis

\_\_\_\_\_ Allergic conjunctivitis

\_\_\_\_\_ Allergy evaluation

\_\_\_\_\_ Urticaria/Angioedema

\_\_\_\_\_ Anaphylaxis

\_\_\_\_\_ Asthma

\_\_\_\_\_ Food allergy

\_\_\_\_\_ Eosinophilic gastrointestinal disorders

\_\_\_\_\_ Cutaneous allergy

\_\_\_\_\_ Atopic dermatitis

\_\_\_\_\_ Contact dermatitis

\_\_\_\_\_ Immunodeficiency

\_\_\_\_\_ Recurrent infections

\_\_\_\_\_ Evaluation for immunodeficiency

\_\_\_\_\_ HIV

\_\_\_\_\_ Primary immunodeficiency diseases

\_\_\_\_\_ Drug allergy

\_\_\_\_\_ NSAID sensitivity

\_\_\_\_\_ Insect/venom allergy

**Other** \_\_\_\_\_

**Board certified Allergists/Immunologists on staff (number & names):**

Full-time # \_\_\_\_\_ Names: \_\_\_\_\_  
\_\_\_\_\_

Part-time # \_\_\_\_\_ Names: \_\_\_\_\_  
\_\_\_\_\_

**You may request specific speakers (who will be considered if they are AAP SOAI members):**

\_\_\_\_\_

**Please briefly describe a sample schedule of activities in which the visiting professor will participate during 1-2 days (function, day of the week, time, estimated number of attendees):**

\_\_\_\_\_  
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**If selected for a Visiting Professorship, the AAP Section on Allergy/Immunology will select a Visiting Professor whose expertise best meets your needs. The Visiting Professor will then work with your institution to identify specific topics and determine a mutually convenient time for the visit to take place.**

\_\_\_\_\_  
Signature of Dept. Chair or Residency Program Director

\_\_\_\_\_  
Date

**Please return by mail, email, or fax to:**

Debra Burrowes  
Manager, Section on Allergy/Immunology  
American Academy of Pediatrics  
141 Northwest Point Blvd.  
Elk Grove Village, IL 60007-1098  
Phone: (847) 434-4927  
Fax: (847) 434-8000  
E-mail: [dburrowes@aap.org](mailto:dburrowes@aap.org)

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