



# MEMBERSHIP APPLICATION

2209 Dickens Road | Richmond, Virginia 23230-2005  
800-741-2626 | 804-565-6370 | Fax: 804-282-0090  
E-mail: greg@societyhq.com | www.aoao.org

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Male  Female Birth Year: \_\_\_\_\_ Preferred Contact Address:  Mailing  Billing

Mailing Address: \_\_\_\_\_ Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ City: \_\_\_\_\_

State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**E-mail:** \_\_\_\_\_ Address to be published in directory or web site?  Mailing  Billing  Neither

**Secondary E-mail:** \_\_\_\_\_ AOA #: \_\_\_\_\_

Note: The AOA does not provide member phone/email information to outside vendors. Please supply your email address to expedite important AOA communications in a more timely and cost effective method.

## DOCTORAL AND POSTDOCTORAL TRAINING

Undergraduate Education: \_\_\_\_\_ Location: \_\_\_\_\_ Dates: \_\_\_\_\_

Advanced degrees?: \_\_\_\_\_

Osteopathic Medical School \_\_\_\_\_ Location: \_\_\_\_\_ End Date: \_\_\_\_\_

Residency Institution: \_\_\_\_\_ Location: \_\_\_\_\_ End Date: \_\_\_\_\_

Fellowship Institution: \_\_\_\_\_ Specialty: \_\_\_\_\_ End Date: \_\_\_\_\_

Are you board eligible?  Yes  No Are you board certified?  Yes  No

Academic Affiliation(s): \_\_\_\_\_

Hospital Staff Positions Currently Held: \_\_\_\_\_

Primary Institution and Location: \_\_\_\_\_

Specialty: \_\_\_\_\_

If accepted for membership, I agree to abide by the Code of Ethics and the Constitution and Bylaws of AOA. By Submission of this document, I authorize release of the information contained herein and in membership files of those organizations and hospitals to which I may subsequently apply for membership, and the release to AOA by organizations and hospitals of information relative to my previous membership in those organizations. I am a resident or a licensed physician in compliance with the state board of medical licensure and/or discipline's order.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

All applicants will be reviewed by AOA, and applicants will receive prompt notice when approved.

- Active ..... \$350
- Associate.....\$200
- Allied Health Professional..... \$175
- Military ..... \$200
- Disabled.....\$100

**Candidate Members must apply online at <https://www2.aoao.org/forms/memberapp.iphtml>**

**If you would like to add a section to your membership, check off all that apply.**

- Adult Reconstruction Section ..... \$100
- Hand Section.....\$50
- Spine Section.....\$100
- Trauma Section ..... \$100
- Foot & Ankle Section ..... \$100
- Pediatric Section .....\$100
- Sports Section.....\$100
- Shoulder & Elbow Section ..... \$100
- Women's Orthopedic Section.....\$50

### Payment Options (Please do not send cash for payment)

Check or Money Order Enclosed (US Funds) Made Payable to: AOA, 2209 Dickens Rd., Richmond, VA 23230-2005.

AmEx  Mastercard  Visa  Discover Card Number: \_\_\_\_\_

Printed Name on Card \_\_\_\_\_ Exp. Date \_\_\_\_\_

Billing Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature \_\_\_\_\_ CVV Security Code\* \_\_\_\_\_

\*CVV code is the three digit number on the back of VISA or MC or 4 digit number on the front of AMEX card above the account number.