



MEMBERSHIP APPLICATION

2209 Dickens Road | Richmond, Virginia 23230-2005

800-741-2626 | 804-565-6370 | Fax: 804-282-0090

E-mail: sarabeth@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: _____

Cell Phone*: _____ Fax: _____ Phone: _____ Fax: _____

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

Secondary E-mail: _____ AOA #: _____

* Opt-in for convenient texting updates and communications from 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

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 (Select one or more of the following specialties):

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Adult Reconstruction | <input type="checkbox"/> Hand | <input type="checkbox"/> Pediatric | <input type="checkbox"/> Spine |
| <input type="checkbox"/> Foot and Ankle | <input type="checkbox"/> Hand and Elbow | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> General | <input type="checkbox"/> Musculoskeletal Oncology | <input type="checkbox"/> Shoulder and Elbow | <input type="checkbox"/> Trauma |

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.

- | | |
|---|---|
| <input type="checkbox"/> Active \$600 | <input type="checkbox"/> Military \$250 |
| <input type="checkbox"/> Associate \$250 | <input type="checkbox"/> Disabled \$150 |
| <input type="checkbox"/> Allied Health Professional \$225 | |

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.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Adult Reconstruction Section \$100 | <input type="checkbox"/> Hand Section \$50 | <input type="checkbox"/> Spine Section \$100 | <input type="checkbox"/> Trauma Section \$100 |
| <input type="checkbox"/> Foot & Ankle Section \$100 | <input type="checkbox"/> Pediatric Section \$100 | <input type="checkbox"/> Sports Section \$100 | <input type="checkbox"/> Shoulder & Elbow Section \$100 |
| <input type="checkbox"/> 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.
 Credit card payments may be submitted via fax: 804-282-0090

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.