



Member Consent And Compliance

I, the undersigned, attest that the information on this application is complete to the best of my knowledge. I understand that by providing my fax number I consent to receive faxes sent by or on behalf of the OOA. I understand that the OOA will not share my fax number with other organizations.

If accepted as a member, I agree to comply with the OOA Constitution and Bylaws and the principles embodied in its Code of Ethics. I further understand that I shall be considered a provisional member until such time as my application is approved by the OOA Board of Trustees and my local academy and my name is printed in the association's official publication, *The Buckeye Osteopathic Physician*.

Signature of applicant _____

Date _____

Instructions For Completing OOA Membership Application

1 • Please complete the front of the application and sign the back as specified.

2 • Annual dues are as follows. Please specify the category that applies to you. At the bottom of this sheet please explain any mitigating circumstances that may be unclear. Membership year of the OOA runs May 1 to April 30.

- Student (\$0)
- Intern (\$0)
- Resident (\$0)
- Fellow (\$0)
- Regular Member (\$525 & Academy)

Please Note:

When you join the OOA, to be a member in good standing, you must also join the District Academy. The OOA will bill you directly.

3 • Send application along with a check made payable to "OOA".
If charging your dues, please complete the following:

- MasterCard, Visa, Discover and American Express accepted

Card Number _____

Expiration Date _____

Cardholder's Name _____

Signature _____

4 • Prorating of dues: The membership year of the Ohio Osteopathic Association runs from May 1 to April 30. After the first quarter, the annual dues of physicians entering into the membership of the OOA must be paid in full. The dues are then prorated on a monthly basis for the remainder of the current fiscal year, and the balance is applied as partial payment on dues for the succeeding year. Prorating of dues does not apply to a person making application for renewal of membership within the same fiscal year in which he or she was dropped from membership for non-payment of dues.

Comments:

Questions regarding membership should be directed to the OOA's Membership Director at 800/234/4848.



OHIO OSTEOPATHIC ASSOCIATION
MEMBERSHIP APPLICATION

AOA Membership Number

LAST NAME		FIRST NAME		M.I.	
OFFICE ADDRESS Street		City	County	State	Zip
HOME ADDRESS Street		City	County	State	Zip
OFFICE PHONE	OFFICE FAX	HOME PHONE	ADDRESS RELEASE TO NON-OOA <input type="checkbox"/> Yes <input type="checkbox"/> No	PREFER MAIL <input type="checkbox"/> Home <input type="checkbox"/> Office	
E-MAIL ADDRESS		WEBSITE		PREFER COMMUNICATION <input type="checkbox"/> E-MAIL <input type="checkbox"/> FAX	
PLACE OF BIRTH		BIRTH DATE (mo / day / yr)	MARITAL STATUS <input type="checkbox"/> Married <input type="checkbox"/> Single	SPOUSE'S NAME	
OPTIONAL - ETHNIC BACKGROUND <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian American <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> White/Caucasian					GENDER
COLLEGE - UNDERGRADUATE		LOCATION	MAJOR FIELD	DEGREE	DATE GRAD. (mo / yr)
COLLEGE - GRADUATE		LOCATION	MAJOR FIELD	DEGREE	DATE GRAD. (mo / yr)
COLLEGE - OSTEOPATHIC					DATE GRAD. (mo / yr)

HOSPITAL	LOCATION	ATTENDANCE (from mo / yr to mo / yr)	SPECIALTY
INTERNSHIP			
RESIDENCY			
RESIDENCY			
FELLOWSHIP			

CERTIFICATION BOARD NAME	CERTIFICATION DATE (mo / yr)	SPECIALTY

STATE OF LICENSE	LICENSE NUMBER	ISSUE DATE (mo / yr)	CURRENT HOSPITAL PRIVILEGES (hospital / location)

In Private Practice? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Private, is it a group practice? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of DOs _____	Number of Professional Offices _____	ACCEPT <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Industrial / WC
If not in private practice, indicate one: <input type="checkbox"/> Internship <input type="checkbox"/> Residency <input type="checkbox"/> Full-time Faculty <input type="checkbox"/> Full-time Hospital <input type="checkbox"/> Fellowship <input type="checkbox"/> Military Service <input type="checkbox"/> Totally retired <input type="checkbox"/> Semi-retired <input type="checkbox"/> Public Health Service <input type="checkbox"/> Civil Service <input type="checkbox"/> Student <input type="checkbox"/> Other _____				
Type of Practice <input type="checkbox"/> FP <input type="checkbox"/> Other _____	Percent devoted to specialty _____%	Sub-specialty _____	Percent of practice devoted to OMT _____%	

PROFESSIONAL MEMBERSHIPS - SOCIETY NAME	FELLOW	PROFESSIONAL MEMBERSHIPS - SOCIETY NAME	FELLOW

COMPLETE BOTH SIDES

RETURN TO: Ohio Osteopathic Association • 53 West Third Avenue • PO Box 8130 • Columbus, Ohio 43201-0130