ACTIVE MEMBERSHIP APPLICATION

Date of Application __________________

Please type or print legibly
(Applications will be returned if not legible)

Name ____ Email ____________________

Address of Current Practice ____________________________________ Phone ( ) ______________

____

City State Zip County

Residential Address ____ Phone ( ) ______________

____

City State Zip County

Please send mail to ( )Office ( )Residence Fax ( ) ______________________

AOA# ______________ Birthdate ______________ Spouse's Name ______________________

TRAINING

Pre-Medical College ____________________________________ Degree ________ Year ______

Osteopathic Medical College ________________________________ Class Year __________

Post Graduate Training ____

____

____

Specialty ____ ( )Cert. ( )Elig.

Certifying Board ____

PRACTICE INFORMATION

WA State License Number ______________________________ Date Issued ________________

Other State Licenses ____

Present Practice Focus ____

Hospital Staff (Present) ____

____

Hospital Staff (Past) ____

____

Other State Divisional Society Memberships (Past and Present) ______________________________

____

Have you ever had a license limited, suspended or revoked? No_______ Yes_______

If yes, please attach explanation.

Has your ability to prescribe pharmaceuticals ever been limited or suspended? No_______ Yes_______

If yes, please attach explanation.

PREVIOUS PRACTICE

List in chronological order beginning with most recent or attach CV ______________________________

____

"By my signature, I hereby authorize release of the information contained in this application and WOMA membership file to those organizations or hospitals to whom I may subsequently apply for membership; and release to WOMA, by organizations, agencies and hospitals of information relative to my membership in those organizations and my professional practice. I understand that withholding or falsification of information will result in denial of membership."

Enclosed is my application fee of $25. _____ Enclosed is my dues. _____ Please bill me.

First year of practice in WA-$150; Second year of practice in WA-$250; Third or more year of pactice in WA- $600

Signature of Applicant ____ Date ______________

Please list at least one WOMA member who can recommend you for WOMA membership: ____________________

If you do not know any WOMA members, please indicate so here: __________

( )Approved ( )Disapproved ( )Other

WOMA Officer/Executive Director ______________________________________ Date ______________

Return to W.O.M.A. / P.O. Box 16486 / Seattle, WA 98116 / (206) 937-5358 / FAX (206) 933-6529/www.woma.org