POST GRADUATE MEMBERSHIP APPLICATION

Date of Application ____________

Please Type or Print Legibly
(Applications will be returned if not legible)

Name ________________________ Home Phone (   ) ____________
Current Mailing Address ________________________
____
(City) (County) (State) (Zip)

Address of Current School/Training ________________________ Work Phone (   ) ____________
____
(City) (County) (State) (Zip)

Permanent Resident Address ________________________ Phone (   ) ____________
____
(City) (County) (State) (Zip)

Email Address ________________________

AOA# ____________ **Birthdate** ____________ **Spouse's Name** ____________

Should I be granted membership, I promise to read, understand and comply with all the requirements of the Constitution and By-Laws of the WOMA and conduct myself and practice in accordance with the Code of Ethics of the WOMA and the American Osteopathic Association.

Training (If not applicable, state N/A; If unknown, state Unknown):

Pre-Medical College ________________________ Degree ________ Year ________
Osteopathic Medical College ________________________ ClassYear ________
Internship at ________________________ Year ________
Residency (specialty & location) ________________________ Years ________
Fellowship ________________________ Years ________
Practice Specialty ________________________

"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."

Signature of Applicant ________________________ Date ____________

( )Approved ( )Disapproved ( )Other

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