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)
- ❑ First-year OOA Member ($100 & Academy)*
- ❑ Second-year OOA Member ($200 & Academy)
- ❑ Third-year OOA Member ($300 & Academy)
- ❑ Fourth-year OOA Member ($400 & Academy)
- ❑ Fifth-year OOA Member & After ($500 & Academy)
- ❑ Out-of-State Member ($50)
- ❑ Uniformed Services ($150 & Academy)**

Please Note:
When you join the OOA, you also automatically become a member of your District Academy. You will be billed for local dues by the OOA or directly by your district.
* "First-Year of Membership" applies only to those applicants who have never been a dues-paying, in-state member of the OOA. Any previous member will be reinstated at the appropriate year-of-member rate.

** "Uniformed Services" means military or U.S. Public Health Service. (Applies after the first year.)

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

Check One: ❑ MasterCard ❑ Visa

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.	SOCIAL SECURITY NUMBER
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 ❑ Yes ❑ No		PREFER MAIL ❑ Home ❑ Office
E-MAIL ADDRESS		WEBSITE			PREFER COMMUNICATION ❑ E-MAIL ❑ FAX
PLACE OF BIRTH	BIRTH DATE (mo / day / yr)	MARITAL STATUS ❑ Married ❑ Single	SPOUSE'S NAME		
OPTIONAL - ETHNIC BACKGROUND ❑ American Indian ❑ Black/African American ❑ Asian American ❑ Latino/Hispanic ❑ White/Caucasian					SEX ❑ Female ❑ Male
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 ? ❑ Yes ❑ No	If Private, is it a group practice? ❑ Yes - Number of DOs _____ ❑ No	Number of Professional Offices	ACCEPT ❑ Medicare ❑ Medicaid ❑ Industrial / WC
If not in private practice, indicate one: ❑ Internship ❑ Residency ❑ Full-time Faculty ❑ Full-time Hospital ❑ Fellowship ❑ Military Service ❑ Totally retired ❑ Semi-retired ❑ Public Health Service ❑ Civil Service ❑ Student ❑ Other _____			
Type of Practice ❑ FP ❑ Other _____	Percent devoted to specialty _____%	Sub-specialty _____ Percent of practice _____%	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