Application for Candidate Membership

3 Bethesda Metro Center • Suite 508 • Bethesda, 20814 • 301 656-8877 • FAX 301 656-7133

PLEASE PRINT OR TYPE

Name____AOA #____________________

Preferred Mailing Address____

City______________________________State__________ZIP________________

Home Phone__________________________ Work Phone_____________________________

Cell Phone __________________FAX________________________Date of Birth__________

Email Address_______________________________Name of Spouse____________________

Academic Degree Date__________ — __________ School___________________________
FROM TO

Medical School____Year Graduated________

Internship Institution____Dates____________

Medicine Residency Training Institution____________________________Dates____________

Date Appointed____

I hereby certify that the above statements made by me are true to the best of my knowledge and belief and that I will give every possible aid to the Credentials Committee in its investigation of my qualifications as a candidate. I futhermore promise that if elected to candidacy in the American College of Osteopathic Internists, I will abide by the rules and regulations of the College and will endeavor to support the ethics of my profession and the good name of the American College of Osteopathic Internists and the osteopathic profession.

Signature of Applicant____Date______________

I certify that the above statements are true to the best of my knowledge and belief and recommend this applicant to the Credentials Committee and to the Board of Directors of the American College of Osteopathic Internists for Candidate Membership.

Signature of Program Director_____________________________________Date______________

Note: Return or fax this application to the above address

FOR COLLEGE USE ONLY: Application Received on__________________________

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