American College of Osteopathic Internists

Application for Associate Membership

11400 Rockville Pike • Suite 801 • Rockville, MD 20852 • 301 231-8877 • Fax 301 231-6099

PLEASE PRINT OR TYPE

Name_____AOA#_____

Preferred Mailing Address_____

City_____State_____ZIP_____

Home Phone (_____)_____Work Phone (_____)_____

Fax (_____)_____Cell Phone (_____)_____Date of Birth_____

Email Address_____

Hospital Affiliation_____

Medical School_____Year Graduated_____

Internship Institution_____Dates_____

Residency Training Institution_____Dates_____

Specialty Area_____

AOA/ABMS Certification in Subspecialty #_____Dates_____
(circle one)

Signature of Applicant_____Date_____

Note: Return or fax this application to the above address

FOR COLLEGE USE ONLY: Member Form Received _____
Credentials Committee Action_____
Board of Directors Action_____