



American College of Osteopathic Internists

Application for Resident 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 _____

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 furthermore 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 _____