AMERICAN COLLEGE OF OSTEOPATHIC INTERNISTS

Active Membership Application Form

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

PLEASE PRINT OR TYPE

AOA#_____

Name_____Date of Birth_____

Preferred
Mailing Address_____Name of Spouse_____

City_____State_____ZIP_____

Home Phone (_____)_____Work Phone (_____)_____

Fax (_____)_____Cell Phone (_____)_____

Email Address_____

Hospital Affiliation_____

Medical School_____Year Graduated_____

Internship Institution_____Dates_____

Medicine Residency Training Institution_____Dates_____

_____

AOBIM Certification in Internal Medicine #_____Dates_____

ABIM Certification in Internal Medicine #_____Dates_____

Other Certification in Internal Medicine (please list)_____Dates_____

Subspecialty Training Institution_____Dates_____

AOBIM Certification in Subspecialty #_____Dates_____

Other Subspecialty Certification (please list)_____Dates_____

Signature of Applicant_____Date_____

Note: Return or fax this application to the above address

FOR COLLEGE USE ONLY: Member Form Received _____

Credentials Committee Action_____