



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 _____