

**Free AOA membership for the cost of AMOPS Dues
(Only for those who were not AOA members as of June 1, 2006)**

Mailing Address

Rank _____ Name _____

Address _____

City _____ State _____ Zip _____

Above address is Home () or Work ()

Service Branch _____ AOA# _____

Osteopathic College & Graduation Year _____

Please let us have your preferred e-mail address and please let us know of any changes in your e-mail address as soon as possible. Most of our future communication with the membership will be via e-mail to better serve you and save on postage costs.

E-Mail _____

Membership Fee: \$100

Please provide a check made out to AMOPS or your credit card information.

Visa MasterCard

Account Number _____

Exp. Date ____/____/____ (mm/yyyy)

Name on account _____

Phone # _____

Signature _____

Amount Charged \$ _____

A Few Questions:

Do you have an unrestricted license to practice medicine in the state listed in your address? Yes () No ()

State License number: _____ Date Issued: _____

Has your license ever been suspended or revoked? (If so, please provide details separately) Yes () No ()

Have you ever been convicted of a felony offense? (If so, please provide details separately) Yes () No ()

I am applying for membership in the above specified organization and the American Osteopathic Association, and I agree to comply with the constitution, bylaws and code of ethics of these organizations.

Signature: _____ Date: _____

**Please mail this form and your check to: AMOPS, 1796 Severn Hills Lane, Severn, MD 21144-1061
If charging, you may fax completed form to: 410-519-7657**