2544 Blairstone Pines Drive
Tallahassee, Florida 32301
Phone: (850) 878-7364
Fax: (850) 942-7538
Toll Free: (800) 226-3662
www.foma.org

FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION
MEMBERSHIP APPLICATION

PLEASE INDICATE MEMBERSHIP TYPE BY PLACING AN "X" IN THE BOX TO THE LEFT OF THE CATEGORY.

MEMBERSHIP CATEGORY	DUES RATE
❑ ACTIVE/PROVISIONAL	$425.00
❑ 2ND YEAR PRACTICE	$300.00
❑ 1ST YEAR PRACTICE	$150.00
❑ OUT OF STATE	$125.00
❑ MILITARY	$50.00
❑ INACTIVE (RETIRED)	$50.00
❑ PUBLIC HEALTH	$50.00
❑ RESIDENT	$50.00
❑ INTERN/STUDENT	NO FEE

INSTRUCTIONS TO APPLICANT:

Please print or type requested information in space provided. Please complete the application in its entirety. If the answer is "no", "none" or "not applicable", please indicate. If additional space is required, attach a properly identified addendum.

PERSONAL INFORMATION

AOA # ________________________ FL LICENSE # _____________________________ DATE:______________

FULL NAME:____

DATE OF BIRTH: ________________ SSN#: __________________ SPECIALTY:_________________________

MARITAL STATUS: __________________ SPOUSE'S NAME:____

Please check box to the left of the address you would prefer to receive FOMA publications and mailings.

OFFICE ADDRESS:____

____

CITY: ________________________________ STATE: ______________________ ZIP: _____________________

PHONE: _______________________ FAX: _______________________ EMAIL: ___________________________

HOME ADDRESS:____

____

CITY: ______________________________ STATE: _______________________ ZIP: _______________________

PHONE: _______________________ FAX: _______________________ EMAIL: ____________________________

PRACTICE HISTORY

Please include and state any revocations of license or privilege.
PREVIOUS PRACTICE (if any):____
HOSPITAL STAFF (present):____
OTHER STATE LICENSE(S): STATE: _______________ LICENSE#: ____________ DATE: ____________
STATE: _______________ LICENSE#: ____________ DATE: ____________

EDUCATION

PRE-OSTEOPATHIC TRAINING

COLLEGE:___________________________________

DEGREE: ____________________ YEAR:_________

OSTEOPATHIC TRAINING

COLLEGE:___________________________________

DEGREE: ____________________ YEAR: _________

INTERNSHIP PROGRAM

HOSPITAL:__________________________________

CITY:________________________STATE:_________

DATES: FROM ______________ TO______________

RESIDENCY PROGRAM

HOSPITAL:__________________________________

CITY: _______________________ STATE:_________

DATES: FROM ______________ TO______________

SPECIALTY:_________________________________

CERTIFICATION ** (must include copy of certificate with application)

CERTIFYING BOARD: _______________________ DATE: ____________ SPECIALTY:_______________________

CERTIFYING BOARD: _______________________ DATE: ____________ SPECIALTY:_______________________

DISCIPLINARY HISTORY

Have you ever been suspended, censored, disciplined or disqualified by any licensing or regulatory agency, professional association or society? (Circle response)

YES **NO** IF YES, please give details on a separate sheet of paper.

By my signature, I hereby agree to practice, comply, and govern my conduct in accordance with the code of ethics of the FOMA and such other standards of conduct and practice ethics adopted by the Association and make application for membership in the FOMA.

I hereby authorize release of the information contained in this application and membership file to those organizations or hospitals to which I may subsequently apply for membership and the release to FOMA by organizations and hospitals of information relative to my previous membership in those organizations.

SIGNATURE: ____ DATE: ________________

REFERRED BY (if applicable): ______________________________________ DATE: _________________

PAYMENT INFORMATION

Enclosed is payment in the amount of $ ___________ for FOMA membership dues. It is understood that this amount is to be returned if the FOMA Board of Trustees does not approve the application.

METHOD OF PAYMENT (Circle): **CHECK / MASTERCARD / VISA / AMEX / DISCOVER**

CARD #: _________________________

SIGNATURE: _____________________ EXP DATE: _________ SECURITY CODE: ________

PLEASE NOTE: Included within FOMA Active Membership dues ($425) is a twenty five dollar contribution to the Florida Osteopathic Medical Association-Political Action Committee (FOMA-PAC) which uses those contributions to help elect friends of osteopathic medicine to State and Local office and utilizes funds for advancing the interests of the FOMA. Contributions to FOMA-PAC are voluntary. If you do not wish to contribute to FOMA-PAC, you may request that the contribution be utilized for non-PAC purposes of refunded to you by making a written request to the FOMA office. Dues payments and contributions to the FOMA-PAC are not deductible as charitable contributions for Federal Income Tax purposes. FOMA dues payments may be partially deductible by members as an ordinary and necessary business expense. Twenty percent of the dues are not deductible in accordance with the Internal Revenue Code (IRC) Section 6033.

ADDITIONAL INSTRUCTIONS: To complete the processing of your application the following items are requested:
1) Recent Photograph 2) Copy of your current Florida License 3) Copy of your certification certificate

Mail or fax completed application with payment to:

Mail: FOMA – 2544 Blairstone Pines Drive – Tallahassee, FL 32301 / Fax: (850) 942-7538