



FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION  
ASSOCIATE MEMBERSHIP APPLICATION

**FOMA Associate Membership Dues are \$175.00**

PLEASE INDICATE ASSOCIATE MEMBERSHIP TYPE BELOW.

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

- Allopathic Physician (MD)
- Physician Assistant (PA)
- Advanced Registered Nurse Practitioner (ARNP)
- Certified Nursing Assistant (CNA)
- Other: (please specify) \_\_\_\_\_

**INSTRUCTIONS:**

Please print or type requested information below. If additional space is needed, please attach to application.

**PERSONAL INFORMATION**

DATE: \_\_\_\_\_ FL LICENSE # \_\_\_\_\_

FULL NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SSN#: \_\_\_\_\_

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-MEDICAL TRAINING**

COLLEGE: \_\_\_\_\_

DEGREE: \_\_\_\_\_ YEAR: \_\_\_\_\_

**MEDICAL TRAINING**

COLLEGE: \_\_\_\_\_

DEGREE: \_\_\_\_\_ YEAR: \_\_\_\_\_

**SPECIALTY/CERTIFICATION**

SPECIALTY: \_\_\_\_\_

CERTIFICATION(S): \_\_\_\_\_ DATE: \_\_\_\_\_

**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: \_\_\_\_\_

SPONSORING MEMBER (if applicable): \_\_\_\_\_ DATE: \_\_\_\_\_

**PAYMENT INFORMATION**

Enclosed is payment in the amount of \$ **175.00** 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.

PAYMENT (Circle): CHECK/MC/VISA/AMEX CARD #: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_ V-CODE: \_\_\_\_\_

**ADDITIONAL INSTRUCTIONS:** To complete the processing of your application the following items are requested:

- 1) Recent Photograph
- 2) Copy of your current Florida License

Mail or fax completed application, with payment to:  
 FOMA  
 2544 Blairstone Pines Drive  
 Tallahassee, FL 32301  
 Fax (850) 942-7538  
 Visit our website at [www.foma.org](http://www.foma.org)