



FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION MEMBERSHIP APPLICATION

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

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

MEMBERSHIP CATEGORY	DUES RATE
<input type="checkbox"/> ACTIVE/PROVISIONAL	\$425.00
<input type="checkbox"/> 2ND YEAR PRACTICE	\$300.00
<input type="checkbox"/> 1ST YEAR PRACTICE	\$150.00
<input type="checkbox"/> OUT OF STATE	\$175.00
<input type="checkbox"/> MILITARY	\$50.00
<input type="checkbox"/> INACTIVE (RETIRED)	\$50.00
<input type="checkbox"/> PUBLIC HEALTH	\$50.00
<input type="checkbox"/> RESIDENT	\$50.00
<input type="checkbox"/> 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: _____ 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: _____

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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