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

FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION
ASSOCIATE MEMBERSHIP APPLICATION

FOMA Associate Membership Dues are $175.00

PLEASE INDICATE ASSOCIATE MEMBERSHIP TYPE BELOW.

- ☐ 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: ________________________

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	MEDICAL TRAINING
COLLEGE: ______________________	COLLEGE: ______________________
DEGREE: __________ YEAR: ________	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