The Hull Building
2007 Apalachee Parkway
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: _____ 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.

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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 / The Hull Building
2007 Apalachee Parkway
Tallahassee, FL 32301
Fax (850) 942-7538
Visit our website at www.foma.org