MEMBERSHIP APPLICATION
DELAWARE STATE OSTEOPATHIC MEDICAL SOCIETY

Current annual dues (please check one classification):

__ 1st Year of Practice	$75
__ 2nd Year of Practice	$200
__ 3rd Year of Practice	$300
__ Retired/Intern/Resident	$0

PERSONAL (Please print or type all information)

Name: _____

AOA Number: _____

Business Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Office Telephone #: _____ Office Fax #: _____

E-MAIL ADDRESS (E-mails will be sent for all DSOMS correspondence):

Please print clearly: _____@_____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: _____ Home Fax #: _____

Mobile #: _____

Mailing Preference: __Home __ Office

Date of Birth: _____ Place of Birth: _____

Marital Status: __S __M __D __W Spouse Name: _____

PRACTICE

Resident: _____ Intern: _____ Student: _____

Date started practice: _____

Type of practice: __ Solo __ Group __ Partnership __ Institutional __ Other

Specialty: _____

Subspecialty: _____

Fellowship: _____

Board Certified: ___ Yes ___ No Board Eligible: _____ Date: _____

Specialty College(s): _____

Delaware License #: _____ Date Licensed: _____

Other State License(s): _____

Hospital Affiliation(s): _____
Name of Hospital

EDUCATION

Pre-Osteopathic College: _____

Year Graduated: _____ Degree: _____

Osteopathic College: _____

Year Graduated: _____

Internship: _____
(Institution Name) City/State Year

Residency: _____
(Institution Name) City/State Year

Residency: _____
(Institution Name) City/State Year

OTHER

Additional Post-Graduate Training: _____

List membership in other associations: _____

Honors/professional accomplishments: _____

Teaching or faculty positions: _____ _____

Other comments: _____

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I have indicated the form of payment for my membership dues, with the understanding that the funds will be returned to me should the DSOMS Board of Trustees not approve my application.

Attached is a check made out to "DSOMS" in the amount of $ _____

I hereby agree to practice, comply and govern my conduct in accordance with the Code of Ethics of the Delaware State Osteopathic Medical Society and such standards of conduct and practice ethics adopted by the association. I certify that the answers herein are complete and true to the best of my knowledge. I hereby authorize the release of information to DSOMS for the purpose of investigation of my professional credentials and personal character as needed to process my membership application.

Signature: _____ Date: _____

Please print return completed application with payment to:

Delaware State Osteopathic Medical Society
4142 Stanton-Ogletown Road, #127
Wilmington, DE 19713

Our phone is: (228) 547-3412