



# Massachusetts Osteopathic Society 2018 Membership Application

AOA Member <input type="checkbox"/> Yes <input type="checkbox"/> No		Preferred Email Address:	
If yes, AOA ID:			
<b>Demographic Information</b>			
Name:		Degree: <input type="checkbox"/> DO <input type="checkbox"/> MD Other:	
Office Address: <input type="checkbox"/> This is my preferred contact address			
Institution Name:			
Mailing Address:			
City:	State:	Zip:	Phone: - - Fax: - -
Home Address: <input type="checkbox"/> This is my preferred contact address			
Mailing Address:			
City:	State:	Zip:	Phone: - - Fax: - -
<b>Practice Information</b>			
Specialty:			
Are you accepting new patients for OMT? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you accepting new patients for primary care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
State(s) of License:		If Licensed in MA, enter license #:	
Board Eligible/Cert. <input type="checkbox"/> Yes <input type="checkbox"/> No		Boards:	

## Certification

I certify the above information is accurate and that I am in compliance with the regulations of the State Board of Medical Licensure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Membership Payment

Please choose the appropriate category:

Active (\$195)     Military (\$145)     Retired (\$145)     Student/Resident/Intern (\$0)

Check# \_\_\_\_\_ Enclosed    Please charge my  Visa  MasterCard  Discover  American Express

Card Number: \_\_\_\_\_ Expires: \_\_\_\_\_ Sec. Code: \_\_\_\_\_

\_\_\_\_\_  
Signature