



WEST VIRGINIA SOCIETY OF OSTEOPATHIC MEDICINE, INC.
MEMBERSHIP APPLICATION

Return to: WVSOM | 142 E. Ontario, 4th Fl. | Chicago, IL 60611
Fax: 312-202-8224 | Email: wvsom@osteopathic.org

Name: _____ AOA #: _____

Birthday: _____ Social Security No.: _____ Spouse: _____

Home Address: _____ City, State, Zip: _____

County: _____ Home Phone: _____ Home Fax: _____

Office Address: _____ City, State, Zip: _____

County: _____ Office Phone: _____ Office Fax: _____

Email Address: _____

Include my HOME OFFICE address in the Membership Directory

Membership Type: (Membership privileges begin after acceptance by the Board of Trustees)

- 4 or more years in practice: \$400 1st year in practice: \$100 Out of State DO: \$125
- 3rd year in practice: \$300 Medical Student, PGY I-IV, Resident: FREE Non-DO or WVSOM Staff: \$50
- 2nd year in practice: \$200 Retired Physician: \$25 Life or Honorary Member : FREE

Professional Associations:

OSTEOPATHIC MEDICAL EDUCATION

School: _____ City, State: _____

Attendance From: _____ to _____ Graduation Date: _____

INTERNSHIP

Name of Hospital or Clinic: _____

City, State: _____ Dates: from _____ to _____

Name of Hospital or Clinic: _____

City, State: _____ Dates: from _____ to _____

CONTINUED ON NEXT PAGE

RESIDENCY/FELLOWSHIP

Name of Hospital or Clinic: _____

City, State: _____ Dates: from _____ to _____

Name of Hospital or Clinic: _____

City, State: _____ Dates: from _____ to _____

Type of Residency/Fellowship: _____ Board Certified: _____

PRACTICE RECORD

I am licensed in:

State: _____ License Number: _____ Date: _____ Specialty(s): _____

State: _____ License Number: _____ Date: _____ _____

State: _____ License Number: _____ Date: _____ _____

State: _____ License Number: _____ Date: _____ _____

I have complied (if not, please attach a letter of explanation) with the laws regarding the practice of osteopathic medicine and surgery wherever I have practiced. If I am accepted as a member of WVSOM, Inc., I promise to comply with its Constitution and By-laws and with the Code of Ethics of the American Osteopathic Association and the West Virginia Society of Osteopathic Medicine, Inc.

Physician's Signature

Date

1.

2.

Endorsements: (must be obtained from Active Members)

Please make checks payable to WVSOM, Inc. Amt. Enclosed: _____ Check Number: _____

Visa MasterCard Number: _____ Exp. Date: _____