

**MEMBERSHIP APPLICATION
DELAWARE STATE OSTEOPATHIC
MEDICAL SOCIETY**

Current annual dues (please check one classification):

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

PERSONAL(Please print or type all information

Name: _____ AOA Number: _____

Business Name and Address: _____

Mailing Address: _____

Office Telephone #: _____ Office Fax #: _____

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

Please print clearly: _____@_____

Home Address: _____

Home Telephone #: _____ Home Fax #: _____

Mailing Preference: Home _____ Office _____

Date of Birth: _____ Place of Birth: _____

Marital Status: S M D W Spouse Name: _____

PRACTICE

Date practice started: _____

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

Specialty: _____ Subspecialty: _____

Fellowship: _____

Board Certified: Yes _____ No _____ 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

OTHER

Additional Post-Graduate Training: _____

List membership in other associates: _____

Honors/professional accomplishments: _____

Teaching or faculty positions: _____

Other comments: _____

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 return completed application with payment to:

Delaware State Osteopathic Medical Society
P.O. Box 3315
Newport, DE 19804-4315
(302) 999-9464 Fax (302) 999-7910