

## INDIANA OSTEOPATHIC ASSOCIATION MEMBERSHIP APPLICATION

\_\_\_\_\_  
Name (first) (middle) (last) Degree

\_\_\_\_\_  
Mailing Address (indicate G office or G residence) City State Zip Code

\_\_\_\_\_  
Telephone Numbers (office) (fax) (residence) E-Mail Address Web Site Address

\_\_\_\_\_  
Date of Birth Gender Marital Status Name of Spouse (first) (last)

\_\_\_\_\_  
Spouse Mailing Address (indicate G office or G residence) City State Zip Code

\_\_\_\_\_  
Telephone Numbers (office) (fax) (residence) E-Mail Address Web Site Address

Current Practice Status (indicate G active G inactive (retired) G military G fellowship G residency G internship G student or G other \_\_\_\_\_).

\_\_\_\_\_  
Date Started Practice (training completed) Practice State(s) i.e. IN, etc. Practice Area(s) i.e. FP, etc.

\_\_\_\_\_  
Pre-Osteopathic Medical College (name) (year of graduation) (degree)

\_\_\_\_\_  
Osteopathic Medical College (name) (year of graduation)

\_\_\_\_\_  
Internship Completed At (name) (year) Residency Completed At (name) (year)

\_\_\_\_\_  
Fellowship Completed At (name) (year)

\_\_\_\_\_  
Board Certification(s) i.e. AOBFP, ABFP, etc. (year) Certification(s) of Added Qualification (year)

\_\_\_\_\_  
Fellow(s) i.e. ACOFP, AAFP, etc. (year) AOA Member Number

By my signature, I hereby authorize release of the information contained in this application and my membership file to those organizations or hospitals to whom I may subsequently apply for membership, and the release to IOA by organizations and hospitals of information relative to my previous memberships in those organizations.

I hereby agree to practice, comply, and govern my conduct in accordance with the Code of Ethics of IOA and such other standards of conduct and practice ethics adopted by IOA.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**IOA Member References:**

Dr. \_\_\_\_\_

Dr. \_\_\_\_\_

**Current IOA Dues:**

Active (Third Year of Practice).....\$400.00  
Active (Second Year of Practice).....\$150.00  
Active (First Year of Practice).....\$75.00  
Associate (out-of-state).....\$50.00  
Inactive (retired).....\$25.00

Military.....\$25.00  
Resident.....Complimentary  
Fellow.....Complimentary  
Intern.....Complimentary  
Student.....Complimentary

Attached is \$\_\_\_\_\_, the membership fee, which will be my dues for the current year, with the understanding that it is to be returned to me in case my application is rejected. (No application will be acted on by the Board of Trustees unless it is accompanied by the membership fee.)

G Check (made payable to IOA).

G Charge to: G Visa G Mastercard G Discover G American Express

\_\_\_\_\_  
Card Number Expiration Date CVV Number Authorized Signature

Mail this completed membership application with your dues to **Indiana Osteopathic Association, 3520 Guion Road, Suite 202, Indianapolis, IN 46222.**

(Dues are not deductible as a charitable contribution, but may qualify as an ordinary business expense under the IRS regulations.)

