



American Osteopathic College of Dermatology

AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY

P.O. Box 7525, Kirksville, MO 63501

800-449-2623 660-627-2623 (fax)

RESIDENT MEMBERSHIP APPLICATION

(Please type or print)

****Membership dues, curriculum vitae and a head/shoulder photo must accompany this form.**

Date _____

PERSONAL

Name _____
Last First Middle

AOA # _____ Social Security # _____ Birth date _____
(CONFIDENTIAL) (CONFIDENTIAL)

Primary Office Address _____
Street/P.O. Box City State Zip code

Primary Office Telephone _____ Primary Office Fax _____

Home Telephone _____ E-Mail Address _____
(CONFIDENTIAL)

Preferred Mailing Address _____
Street/P.O. Box City State Zip code

Spouse's Name _____
(CONFIDENTIAL)

EDUCATION

Pre-Osteopathic Education _____
School Degree Date

Osteopathic Education _____
School Degree Date

Internship _____
Hospital City, State Dates

Residency Training _____
Hospital City, State

Specialty Dates

State Medical Licenses Held _____
Give State(s) and License Number



ANNUAL DUES: Payable for calendar year: January 1 – December 31

Resident: D.O. in AOA approved dermatology residency program \$ 75

Please return completed application with check made payable to the American Osteopathic College of Dermatology or provide the requested credit card information.

Credit Card # _____/_____/_____/_____

Visa _____ MasterCard _____ Expiration Date _____

Name appearing on card _____ (please print)

Authorized Signature _____

If elected to membership, I shall abide by all the rules, regulations, Constitution and Bylaws of the American Osteopathic College of Dermatology. I shall pay all dues in a timely manner and conduct myself in an ethical way. I will also do my best to promote the welfare of the American Osteopathic College of Dermatology.

Signed _____

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