



# American Osteopathic College of Dermatology

AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY  
P.O. Box 7525, Kirksville, MO 63501  
800-449-2623 660-627-2623 (fax)  
**STUDENT MEMBERSHIP APPLICATION**  
(Please type or print)

Date \_\_\_\_\_ AOA/AOCD Student \_\_\_\_\_ Intern \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

AOA # \_\_\_\_\_ Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_

Home Mailing Address \_\_\_\_\_  
(CONFIDENTIAL) Street/P.O. Box City State Zip code

Home Telephone \_\_\_\_\_ E-Mail Address \_\_\_\_\_  
(CONFIDENTIAL)

Pre-Osteopathic Education \_\_\_\_\_  
School Degree Date

Osteopathic Education \_\_\_\_\_  
School Degree Date

Internship \_\_\_\_\_  
Hospital City, State Dates

**MEMBERSHIPS/AFFILIATIONS** (Please attach a current curriculum vitae containing all information.)

American Osteopathic Association \_\_\_\_\_  
Dates

State Osteopathic Dermatology Association \_\_\_\_\_  
Give State(s) and Dates

Other Dermatology Affiliations \_\_\_\_\_  
Give Organization Name(s) and Dates

\_\_\_\_\_

Other Civic, Professional and Social Affiliations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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 \_\_\_\_\_

\*\*Membership dues plus a head/shoulder photo must accompany this form. If not elected to membership, all fees and photos will be returned to applicant.

**ANNUAL DUES:** Payable for calendar year: January 1 – December 31      Student/Intern: \$25  
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 \_\_\_\_\_

*Applications will be reviewed by the Membership Committee prior to presentation to the Executive Committee.*

Action taken: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
AOCD Membership Committee Chair

\_\_\_\_\_  
AOCD Secretary/Treasurer