



# American Osteopathic College of Dermatology

AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY  
P.O. Box 7525, Kirksville, MO 63501  
800-449-2623 660-627-2623 (fax)

## MEMBERSHIP APPLICATION

(Please type or print)

Date \_\_\_\_\_ AOA/AOCD Resident \_\_\_\_\_ Practicing Physician \_\_\_\_\_

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

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

E-Mail Address \_\_\_\_\_ Web Site \_\_\_\_\_

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

Primary Office Telephone \_\_\_\_\_ Primary Office Fax \_\_\_\_\_

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

Home Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
(CONFIDENTIAL)

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

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

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

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

Residency Training \_\_\_\_\_  
Hospital City, State

\_\_\_\_\_  
Specialty Dates



Additional Dermatological Training \_\_\_\_\_  
Location \_\_\_\_\_ Dates \_\_\_\_\_

\_\_\_\_\_ Type of Training \_\_\_\_\_

Board Eligible? \_\_\_\_\_ Board Certified? \_\_\_\_\_ % of practice devoted to dermatology \_\_\_\_\_

If yes, list specialty board(s) and date of certification \_\_\_\_\_

Primary Specialty \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

State Medical Licenses Held \_\_\_\_\_  
Give State(s) and License Number

Hospital Affiliations \_\_\_\_\_  
Give Hospital Name(s) and Address

**MEMBERSHIPS/AFFILIATIONS** (You may 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 \_\_\_\_\_

**PROFESSIONAL REFERENCES**

Physicians in practice should request letters of recommendation from these references to be sent directly to the AOCD. Additional references and letters of recommendations attesting to your participation in the practice of dermatology are welcome.

\_\_\_\_\_  
Name Address City State Zip code

\_\_\_\_\_  
Name Address City State Zip code



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. Please include a copy of all training and certification documents. If not elected to membership, all fees and photos will be returned to applicant.

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

Fellow:	D.O., AOBD board certified (Board Cert. # _____) D.O., ABD board certified (Board Cert. # _____)	\$425 \$425
Associate:	D.O. who has completed AOA approved dermatology residency	\$425
Affiliate:	D.O. or M.D. who has completed an ACGME approved dermatology residency or completed a dermatopathology program approved by the ACGME or AOA or who is certified in dermatopathology by the AOBD, ABD or the equivalent pathology board recognized by the AOA or ACGME and a member in good standing of AOA or AAD	\$425

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 Secretary/Treasurer