

AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY
P.O. Box 7525, Kirksville, MO 63501
800-449-2623

MEMBERSHIP APPLICATION

(Please type or print)

Date _____

PERSONAL

AOA/AOCD Resident _____

Practicing Physician _____

Name _____
Last First Middle

AOA # _____ Social Security # _____

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 _____ E-Mail Address _____
(CONFIDENTIAL)

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

EDUCATION

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

Are you Board Eligible? _____ Are you Board Certified? _____

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

PRACTICE

Primary Specialty _____ Secondary Specialty _____

Percentage of practice devoted to dermatology _____

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. # _____) \$300
D.O., ABD board certified (Board Cert. # _____) \$300
- Associate: D.O. who has completed AOA approved dermatology residency \$300
- 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 \$300
- Candidate: 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 _____

Authorized Signature _____

Name appearing on card _____ (please print)

RETURN APPLICATION AND PAYMENT TO: American Osteopathic College of Dermatology
P.O. Box 7525
Kirksville, MO 63501-7525

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

Action taken: _____

Date: _____

AOCD Secretary/Treasurer