



Membership Application

PLEASE TYPE OR PRINT**

Today's Date: _____

AOA#: _____

Last Name _____

First Name _____

Middle Initial _____

Date of Birth: ____ / ____ / ____

Gender : Male Female

Check Preferred Mailing Site:

Company _____

Office Address _____
Street City, State, Zip Wk E-mail _____

Office Phone _____
 & Fax _____ Home E-mail _____

Home Address _____

Licensure State(s)/Number(s) _____
Street City, State, Zip

Membership: **MAKE CHECKS PAYABLE TO WAOPS**

- Active \$400 Resident/Intern \$20 Retired \$50 Student \$20
- First year in practice \$96.25 Second year in practice \$192.50 Third year in practice \$288.75

Current Practice Status _____

Medical School _____
City/State Year

Internship Hospital _____
City/State Year

Residency Hospital _____
City/State Discipline Year

Board Certification _____
City/State Discipline Year

Do You Offer OMT? Yes No If yes, percent of practice involving OMT _____

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE GIVE FULL DETAILS.
 (USE SEPARATE SHEET OF PAPER, IF NEEDED)

- A. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily limited, suspended, or revoked? Yes No
- B. Have any complaints been filed against you with reference to your practice? Yes No
- C. Have your privileges at any hospital ever been voluntarily or involuntarily suspended, diminished, revoked, or not renewed? Yes No
- D. Have you ever been convicted of a felony offense? Yes No

Details _____

LIST ALL CURRENT AND PREVIOUS STATE ASSOCIATIONS AND/OR PROFESSIONAL ORGANIZATIONS:

Can we provide your name to current and prospective osteopathic medical students as a contact for information about the profession or as a resource for rotation/internship/preceptorship opportunities? Yes No

Are you available as a lecturer to the WAOPS? Yes No

If yes, on what subject(s) would you like to speak? _____

If you are not personally interested in speaking, is there anyone you wish to recommend to speak?

Name: _____

Phone: _____ Email: _____

Please mail to the: **Wisconsin Association of Osteopathic Physicians and Surgeons,**
 Attention: Susan Jensen
 6214 Washington Ave, Suite C15
 Racine, WI 53406
 Phone: 262-619-9901
 Fax: 262-619-9902
 Website : www.waops.org
 Email: waops1@yahoo.com or waops2@yahoo.com

****Please be sure to fill out as completely and with as much information as possible on this form to enable us to better review your membership application and ensure you receive timely mailings & notifications. Be sure to notify the waops office when any information changes.**