



MACOMB COUNTY OSTEOPATHIC MEDICAL ASSOCIATION
2065 WEST ROAD, STE A
TRENTON, MI 48183
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E-MAIL: CEARLES © MI-OSTEOPATHIC.ORG

MEMBERSHIP APPLICATION

Resident ___ Intern ___ 1st year ___ Practicing more than one year ___ Other ___ (Explain) _____

AOA # _____ Specialty _____ Date of Birth _____

Name _____

Preferred Mailing Address: Office _____ Home _____ (please check one)

Office Address _____ City _____ Zip _____

Office Phone _____ Office Fax _____

Home Address _____

Home Phone _____ Home Fax _____

E-Mail Address _____ Spouse's Name (if applicable) _____

MEDICAL EDUCATION

Osteopathic College _____ Graduation Date _____

INTERNSHIP

Hospital _____ Located in _____ Specialty _____

Completion Date _____

RESIDENCY

Hospital _____ Located in _____ Completion Date _____

Fellowship _____ Field of Practice _____

CERTIFIED

Certifying Board _____ Date _____

Hospital Affiliations _____

Signature Date

<p>Please charge the following Visa ___ MasterCard ___ Discover ___</p> <p>Charge Card # _____</p> <p>Exp. Date _____</p> <p>(Resident/Interns \$0 1st Year of Practice \$35 More than 1 year in practice \$125)</p>
