



Membership Application

3500 DePauw Blvd., Suite 1080 Indianapolis, Indiana 46268

P: (317) 879-1881 · F: (317) 879-0563

www.academyofosteopathy.org

AOA # _____ Date of birth _____ Citizenship _____ Place of birth (city/state) _____

Name _____ Gender: Male Female
(Last) (First) (M.I.) (Title)

Office name _____

Address _____

City/State _____ Zip _____ Country _____

Phone _____ Fax _____ Email _____

By releasing your Fax number/ E-mail address, you have given the AAO permission to send marketing information regarding courses via Fax/E-mail.

Home Address _____

City/State _____ Zip _____ Country _____

Phone _____ Fax _____ Email _____

By releasing your Fax number/ E-mail address, you have given the AAO permission to send marketing information regarding courses via Fax/E-mail.

Preferred mailing address: Office Home Preferred e-mail: Office Home Preferred phone: Office Home

Please indicate where the AAO may publish online your preferred mailing address and telephone number (check all that apply):

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Medical Education	Institute/Program	City/State	Degree	Year Graduated
Premed College	_____	_____	_____	_____
Medical College	_____	_____	_____	_____
Internship	_____	_____	_____	_____
Residency	_____	_____	_____	_____
Specialty	_____	Licensure State/Number	_____	_____

Medical Societies

American Osteopathic Association Yes No Cranial Academy Yes No Former UAAO member Yes No

International (AAO-approved Registry) Yes No Former NUFA Yes No Other _____

Have you ever been denied or expelled from membership in a country/district/state society, or component society of the AOA or AAO? Yes No

Have you ever been convicted of a felony or violation of any state or federal narcotics act Yes No

Has your license ever been surrendered, suspended, or revoked? Yes No

(If you answered yes to any of the three questions above, please explain on an separate sheet.)

AAO Sponsor/Reference _____

(Not required if graduated from an accredited U.S. osteopathic college)

*Membership in the American Academy of Osteopathy® requires membership in the American Osteopathic Association (AOA).

Membership Categories (please select one) Payment by VISA, M/C, Discover, or personal check in USD only

*Intern/Resident \$40.00 Associate (MD) \$261.00 Please make check payable to "American Academy of Osteopathy"

*1st Year in Practice \$93.00 Supporter \$261.00

*2nd Year in Practice \$185.00 International Affiliate \$288.00 Name as it appears on card _____

*Active \$261.00 International Associate \$288.00 Card # _____

*Active/Joint (2) \$396.00 *Intern/Resident 3 yr. \$106.00 Expiration date _____ 3 digit CVV# _____

*Active/Joint (3) \$564.00 *Intern/Resident 4 yr. \$132.00 Type VISA M/C Discover

In signing this application form, I certify that the above information is correct and complete, and hereby agree to abide by the Constitution and Bylaws of the American Academy of Osteopathy®. I agree to accept the Board of Trustees of the AAO as the sole and only judge to my qualifications to be and remain a member. I hereby authorize the American Academy of Osteopathy® to charge the above credit card for the amount of selected membership. I understand that any money submitted will be refunded if my application is not approved.

Signature _____