



APPLICATION FOR MEMBERSHIP

I wish to apply for:

- Regular Membership (\$250 annual dues)
- Associate/Military/Public Health Membership (\$125 annual dues)
- Resident/Intern Training Membership (\$75 annual dues)
- Out-of-State Membership (\$125 annual dues)
- Fully Retired or Disabled Membership (no dues)
- Student Application (\$30 annual dues)

Last Name: _____ First Name: _____ MI: _____

Preferred Name: _____ AOA#: _____ Virginia Medical License #: _____

Work Address:

Home Address:

Address 1/Practice Name

Address 1

Address 2

Address 2

City, State, Zip

City, State, Zip

Work Phone/Fax

Home Phone/Cell

E-mail Address

Preferred method for VOMA correspondence:

- U.S. Mail E-mail

May we provide your email address to

- Patients? Members?

Preferred address for VOMA correspondence:

- Work Home

Website Address

Are you currently accepting new patients?

- Yes No

May we link to your website for view by

- Patients? Members?

Date of Birth: _____

Spouse's Name: _____

Undergraduate School, Year Graduated, Degree Major:

Additional degrees:

Osteopathic Medical School, Year Graduated:

Residency Training Location, Date (Years):

Primary Practice Focus, Certification:

Secondary Practice Focus: _____

Additional Practice Areas: _____

OMT Utilization (% of cases): _____ %

Specialty procedures (these include scope procedures, acupuncture, sclerotherapy, laser procedures, etc. and will assist with contact referrals within VOMA:

Any additional information:

Are you interested in serving on committees within VOMA? (Current committees include education, legislative, membership, career development and nominating). Yes No

Are you available as a medical lecturer? Yes No

If yes, what topic(s)? _____

Do you accept: Prospective Students Students Residents None

Do you currently have an **unrestricted license** to practice medicine in Virginia? Yes No

Has your license ever been suspended, revoked, surrendered, or otherwise encumbered by any regulatory boards or are you currently under investigation by any regulatory board? (If yes, please provide details separately.) Yes No

Have you ever been convicted of a felony offense? (If yes, please provide details separately.)

Yes No

By signing this form the applicant agrees to abide by the constitution, by-laws and rules of VOMA.

Signature: _____ Date: _____

Please print, complete, and mail this form with your check payable to VOMA to:

Virginia Osteopathic Medical Association
48 East Square Lane
Richmond, VA 23238

VOMA is registered as a 501 (c)(6) corporation. As such, membership dues may not be tax deductible. Please consult a tax professional for further information. VOMA Tax ID #54-1067816.