INDIANA OSTEOPATHIC ASSOCIATION
MEMBERSHIP APPLICATION

Name *(first)* *(middle)* *(last)* **Degree**

Mailing Address *(indicate ☐ office or ☐ residence)* **City** **State** **Zip Code**

Telephone Numbers *(office)* *(fax)* *(residence)* **E-Mail Address** **Web Site Address**

Date of Birth **Gender** **Marital Status** **Name of Spouse** *(first)* *(last)*

Spouse Mailing Address *(indicate ☐ office or ☐ residence)* **City** **State** **Zip Code**

Telephone Numbers *(office)* *(fax)* *(residence)* **E-Mail Address** **Web Site Address**

Current Practice Status *(indicate ☐ active ☐ associate ☐ teaching ☐ fellowship ☐ residency ☐ internship ☐ student ☐ military ☐ inactive or ☐ other_____).*

Date Started Practice *(training completed)* **Practice State(s) i.e. IN, etc.** **Practice Area(s) i.e. FP, etc.**

Pre-Osteopathic Medical College *(name)* *(year of graduation)* *(degree)*

Osteopathic Medical College *(name)* *(year of graduation)*

Internship Completed At *(name)* *(year)* **Residency Completed At** *(name)* *(year)*

Fellowship Completed At *(name)* *(year)*

Board Certification(s) i.e. AOBFP, ABFP, etc. *(year)* **Certification(s) of Added Qualification** *(year)*

Fellow(s) i.e. ACOFP, AAFP, etc. *(year)* **AOA Member Number**

By my signature, I hereby authorize release of the information contained in this application and my membership file to those organizations or hospitals to whom I may subsequently apply for membership, and the release to the IOA by organizations and hospitals of information relative to my previous memberships in those organizations.

I hereby agree to practice, comply, and govern my conduct in accordance with the Code of Ethics of the IOA and such other standards of conduct and practice ethics adopted by the IOA.

Signature Date

Current IOA Dues:

Active (Third+ Year of Practice)……..$400.00
Active (Second Year of Practice)……..$300.00
Active (First Year of Practice)……..$200.00
Associate……..$200.00
Teaching……..$200.00
Fellow……..….$ 75.00

Resident……....$ 75.00
Intern……$ 75.00
Student (Second – Fourth Year)……$ 50.00
Military.....$ 25.00
Inactive……..$ 25.00
Student (First Year)…….Complimentary

Attached is $_____, the membership fee, which will be my dues for the current year, with the understanding that it is to be returned to me in case my application is rejected. (No application will be acted on by the Board of Trustees unless it is accompanied by the membership fee.)

☐ Check *(made payable to IOA).* ☐ Charge to: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Card Number Expiration Date CVV Number Authorized Signature

Mail this completed membership application with your dues to **Indiana Osteopathic Association, 3200 Cold Spring Road, Michael A. Evans Center for Health Sciences, Suite 107, Indianapolis, IN 46222.**

(Dues are not deductible as a charitable contribution, but may qualify as an ordinary business expense under the IRS regulations.)