



County Osteopathic Medical Associations Membership Application

Member Status:

- ☐ I am in full-active practice ☐ I am in full-active practice 1st Year of Practice Post-Residency
☐ 2nd Year of Practice Post-Residency ☐ 3rd year of Practice Post Residency ☐ First year practicing
☐ I work 20 hours or less per week ☐ I am currently in active military duty

☐ Male ☐ Female

First Name: _____ MI: _____ Last Name: _____ ☐ DO or ☐ MD

Nickname or Preferred Form of Legal Name: _____

Maiden Name (if applicable) _____ Job Title: _____

Work Phone: _____ Work Fax: _____

Home Phone: _____ Cell: _____ Email: _____

Office Address: ☐ Preferred Mail ☐ Preferred Bill ☐ Preferred Mail and Bill

Practice Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Address: ☐ Preferred Mail ☐ Preferred Bill ☐ Preferred Mail and Bill

Street: _____

City: _____ State: _____ Zip: _____

Please base my county medical society membership on the county of my (if addresses are in different counties): ☐ Office Address ☐ Home Address I prefer: ☐ Macomb ☐ Oakland ☐ Wayne

Birth Date: ___/___/___ Marital Status: ☐ Single ☐ Married Spouse's Name _____

Medical School: Graduation Year: _____ Residency Completion Year: _____

Fellowship Program Completion Year: _____

Primary Specialty: _____ Board Certified ☐ Yes ☐ No

I agree to support the County Osteopathic Medical Association Constitution and Bylaws, the Michigan Osteopathic Association Constitution and Bylaws, and the Principles of Ethics of the American Osteopathic Association as applied by the AOA and the MOA Judicial Committees.

SIGNATURE: _____ DATE: _____

When completed, please mail to: PO Box 112, Rockwood, MI 48173 or email to cearles@domoa.org

Dues: Educational (student, resident, intern, fellow) \$0 OCOMA \$100 yearly MCOMA \$125 yearly
Make check payable to indicated county and mail with application. Questions? 517-512-4307