American Osteopathic Academy of Sports Medicine

Membership Application - January 1 through December 31, 2018

Name: _____ **Suffix**: _____ **Birth Date** (optional): _____ **Gender** (optional): _____

Institution: _____

Street Address or P.O. Box No: _____

City: _____ **State/Province**: _____ **Zip/Postal Code**: _____

Phone: _____ **Fax**: _____ **Mailing Address**: ☐ Work ☐ Home

Email: _____ **AOA #**: _____ **BOC #**: _____

Sports Medicine Background

Are you a team physician (including youth sports, high school, college, professional, and special athletic events)?

☐ Yes ☐ No

If yes, please identify the school, organization, or event:

_____

What percent of your practice is related to sports medicine?

☐ ≤25% ☐ 26% - 50% ☐ 51% - 75% ☐ ≥76%

Do you operate a sports medicine clinic full or part time?

☐ Yes ☐ No

Years of sports medicine practice: _____

Medical School: _____

Date of Graduation: _____

Did you complete a Sports Medicine Fellowship?

☐ Yes ☐ No

If yes, Site: _____

Dates: _____

Director: _____

Board Certification: (Please specify Board/DO or MD)

_____ Date: _____

Date of Certification: _____

Contribution

Optional Tax-Deductible Contribution to the AOASM Sports Medicine Foundation:

☐ $50 ☐ $100 ☐ $250 ☐ Other: $ _____

Optional Tax-Deductible Contribution to Support Student Award/Travel:

☐ $50 ☐ $100 ☐ $250 ☐ Other: $ _____

Fellowship Membership

Fellows who join AOASM at the beginning of their fellowship will receive membership benefits until December 31 of the year the fellowship ends.

Membership Categories

Level	*Online/ Print*	*Online*	*None*
Physician	☐ **$365**	☐ **$320**	**N/A**
Early Career *This rate is available to members within one year of their fellowship graduation date.*	☐ **$265**	☐ **$220**	**N/A**
Associate Member *MD, PhD, PA, ATC, PT*	☐ **$340**	☐ **$295**	☐ **$230**
Fellow *Currently participating in a Sports Medicine Fellowship*	❑ **$245**	☐ **$200**	☐ **$100**
Resident/Intern *Provide proof of residency/internship*	☐ **$245**	☐ **$200**	☐ **$100**
Lifetime *Qualified members must be pre-approved by the Board*	☐ **$145**	☐ **$100**	☐ **$0**
Student	☐ **$145**	☐ **$100**	☐ **$0**

Membership Contact Information

☐ Physician Members can be included in our online membership directory, called "Find a D.O." Check this box if you would like to be included in this directory.

☐ Check this box if you would like to receive postal mailings by outside agencies related to our field for advertising purposes.

Payment Total

☐ Check payable to AOASM, US Funds only, drawn on a US Bank

☐ Visa/Mastercard/American Express

Name of Cardholder: _____

Card Number: _____

Expiration Date: _____ CVV: _____

Signature of Cardholder: _____

Please send completed form, payment, and proof of residency/internship or student status (if applicable) to:
AOASM, 2424 American Lane, Madison, WI 53704
Credit card users may fax to 608-443-2474
Questions? Call 608-443-2477
www.aoasm.org