AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

Membership Application—January 1 through December 31, 2019

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

Institution: _____

Street Address or PO Box #: _____

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

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

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

Membership Directory (required)
❒ Yes, please include my information in the online directory.
❒ No, I waive my directory listing benefit.

I am a team physician for the following sports teams:
(check all that apply)

❒ Youth Sports
❒ High School
❒ College
❒ Professional
❒ Special Olympics
❒ USA Team
❒ Olympic Coverage

Please list the teams you cover: _____

_____

What percentage of your practice is related to sports medicine?

❒ 1%-25% ❒ 26%-50% ❒ 51%-75% ❒ 75%-100%

Do you practice in a sports medicine clinic: ❒ **Part Time** ❒ **Full Time**

Years of Practice in Sports Medicine: _____

Name of Medical School: _____

Date of Graduation: _____

Residency Completed At: _____

Date of Completion: _____

Primary Board Certification: _____
❒ DO ❒ MD

Sports Medicine Fellowship Site: _____

Date of Completion: _____

Do You Have a CAQ in Sports Medicine?
❒ Yes ❒ No

❒ I did not complete a sports medicine fellowship

All membership categories, with the exception of Student membership receive an online subscription to the journal.

Membership Categories:

Physician ❒ $320

Early Career ❒ $220
This rate is available to members within one year of their fellowship graduation date.

Associate Member ❒ $295
PhD, PA, ATC, PT

Fellow ❒ $200
Currently participating in a Sports Medicine Fellowship.

Resident/Intern ❒ $200
Provide proof of residency/internship.

Lifetime ❒ $100
Qualified members must be pre-approved by the Board.

Student ❒ $0

❒ I would like to add a print subscription of the journal for $50/year.

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, & proof of residency/internship or student status (if applicable) to:
• AOASM • 2424 American Lane • Madison, WI 53704-3102 • Phone: +1-608-443-2477 • Fax: +1-608-443-2474 • Web: www.aoasm.org • Email: info@aoasm.org •