AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY
P.O. Box 7525, Kirksville, MO 63501
800-449-2623

RESIDENT MEMBERSHIP APPLICATION

(Please type or print)

****Membership dues, curriculum vitae and a head/shoulder photo must accompany this form.**

Date _____

PERSONAL

Name _____ _____ _____
Last First Middle

AOA # _____ Social Security # _____ Birth Date _____
(CONFIDENTIAL) (CONFIDENTIAL)

Primary Office Address _____ _____ _____ _____
Street/P.O. Box City State ZIP

Primary Office Telephone _____ Primary Office Fax _____

Home Telephone _____ E-Mail Address _____
(CONFIDENTIAL)

Preferred Mailing Address _____ _____ _____ _____
Street/P.O. Box City State ZIP

EDUCATION

Pre-Medical Education _____ _____ _____
School Degree Date

Medical Education _____ _____ _____
School Degree Date

Internship _____ _____ _____
Hospital City, State Dates

Residency Training _____ _____
Hospital City, State

_____ _____
Specialty Dates

PRACTICE
State Medical Licenses Held _____
Provide State(s) and License Number

ANNUAL DUES: Payable for calendar year: January 1 – December 31

Resident: D.O. in AOA approved dermatology residency program --- $ 75

Please return completed application with check made payable to the American Osteopathic College of Dermatology or provide the requested credit card information.

Visa ☐ MasterCard ☐ American Express ☐

Credit Card # _____ Expiration Date _____

CVN (Number on back) _____ Billing Address Zip Code _____

Name as it appears on card (please print): _____

Authorized Signature: _____

RETURN APPLICATION AND PAYMENT TO:
American Osteopathic College of Dermatology
P.O. Box 7525
Kirksville, MO 63501-7525

If elected to membership, I shall abide by all the rules, regulations, Constitution and Bylaws of the American Osteopathic College of Dermatology. I shall pay all dues in a timely manner and conduct myself in an ethical way. I will also do my best to promote the welfare of the American Osteopathic College of Dermatology.

Signed _____

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