AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY
P.O. Box 7525, Kirksville, MO 63501
Ph: 800-449-2623 Fax: 660-627-2623

MEMBERSHIP APPLICATION

(Please type or print legibly)

Date: _____ AOA/AOCD Resident _____ Practicing Physician _____

Name: _____
Last First Middle

AOA # _____ Social Security # _____ Birth Date: _____

E-Mail Address: _____ Web Site: _____

Primary Office Address: _____
Street/P.O. Box City State Zip code

Primary Office Telephone: _____ Primary Office Fax: _____

Home/Mobile Telephone: _____

Preferred Mailing Address: _____
Street/P.O. Box City State Zip code

Pre-Medical Education: _____
School Degree Date

Medical Education: _____
School Degree Date

Internship: _____
Hospital City, State Dates

Residency Training: _____
Hospital City, State

_____
Specialty Dates

Additional Dermatological Training: _____
Type of Training Location Dates

Board Eligible (Y/N): _____ Board Certified (Y/N): _____ % of practice devoted to dermatology: _____

If yes, list specialty board(s) and date of certification: _____

Primary Specialty: _____ Secondary Specialty: _____

State Medical Licenses Held: _____
Give State(s) and License Number

Hospital Affiliations: _____
Give Hospital Name(s) and Address

MEMBERSHIPS/AFFILIATIONS *(You may attach a current curriculum vitae containing all information.)*

American Osteopathic Association: _____
Dates

State Dermatology Association: _____
Give State(s) and Dates

Other Dermatology Affiliations (Give Organization Name(s) and Dates): _____

_____

_____

Other Civic, Professional and Social Affiliations: _____

_____

_____

PROFESSIONAL REFERENCES: Physicians in practice should request letters of recommendation from these references to be sent directly to the AOCD. Additional references and letters of recommendations attesting to your participation in the practice of dermatology are welcome.

_____
Name Address City State Zip code

_____
Name Address City State Zip code

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: _____

****Membership dues plus a head/shoulder photo must accompany this form. Please include a copy of all training and certification documents. If not elected to membership, all fees and photos will be returned to applicant.**

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

Fellow:	D.O., AOBD board certified (Board Cert. # _____)	$425
	D.O., or M.D., ABD board certified (Board Cert. # _____)	$425
Associate:	D.O. or M.D. who has completed AOA or ACGME approved dermatology residency	$425

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

Visa ☐ Master Card ☐ American Express ☐

Credit Card #: _____

Expiration Date: _____ CV Code: _____ Billling Zip Code: _____

Name appearing on card: _____ (please print)

Authorized Signature: _____

Applications will be reviewed by the Membership Committee prior to presentation to the Executive Committee.

RETURN APPLICATION AND PAYMENT TO:

AMERICAN OSTEOPATHIC COLLEGE OF DERMATOLOGY
P.O. BOX 7525
KIRKSVILLE, MO 63501

FAXED APPLICATIONS WILL NOT BE ACCEPTED!

Action taken: _____ Date: _____

_____
AOCD Secretary/Treasurer