MSACOFP
MISSOURI SOCIETY OF THE AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS

# Missouri Society of the American College of Osteopathic Family Physicians

## Life Membership Application Form

PO Box 105077 • Jefferson City, MO 65110 • Phone 573-634-4667 • FAX 573.634.5635 • www.msacofp.org

### Life Membership Criteria

The candidate will:

1. Have been a member of the Missouri Society of the American College of Osteopathic Family Physicians for at least the preceding twenty-five (25) years.
2. Shall have reached the age of seventy years or has completed forty years as an osteopathic family physician (as determined from date of graduation from osteopathic medical school), whichever is lowest.
3. At the discretion of the Board of Governors, life membership may also be conferred upon a life member of another state society of the American College of Osteopathic Family Physicians (applicant must provide written verification) who has maintained membership in the Missouri Society of the American College of Osteopathic Family Physicians for the preceding five consecutive years.

### Life Membership Benefits

1. Life members are eligible to receive all benefits and services of regular membership and shall be exempt from payment of annual dues.
2. There is a reduction in the registration fees at all Missouri Society of the American College of Osteopathic Family Physicians seminars.

### Application and Approval Process

- Applications are reviewed once per year and must be submitted in full by the deadline.
- The MSACOFP Board of Governors will review all applications and will make the final determination.
- New Life Members will be recognized at the Society's Annual Winter Scientific Seminar.
- Applications will be accepted by email, mail, FAX or online at *www.msacofp.org*.
- **Deadline for submission is October 30. You will be notified of approval by December 15.**

### Applicant Information: (PRINT OR TYPE)

Name:_____Phone:_____

Email:_____

Address/City/State/Zip:_____

Osteopathic College Attended:_____Year Graduated:_____

Post Graduate Education Program Information:_____

_____

Total Number of Years in Family Medicine:_____

Locations where you have practiced and number of years at each location (Attach Separate Sheet if Necessary):

_____

_____

_____

List Membership in State Family Medicine Societies including years of membership:

_____

***I attest that I have read and meet the criteria above.***

Physician Signature:_____Date:_____