



Illinois Osteopathic Medical Society

Membership Application

(PLEASE PRINT LEGIBLY)

Name:	Title: <input type="checkbox"/> DO <input type="checkbox"/> MD <input type="checkbox"/> Other Contact Preference: <input type="checkbox"/> Work <input type="checkbox"/> Home	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single
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WORK

Address: _____

City: _____ State: _____ Zip Code: _____ – _____ County: _____

Phone: () _____ Fax: () _____ E-mail: _____

HOME

Address: _____

City: _____ State: _____ Zip Code: _____ – _____ County: _____

Phone: () _____ Fax: () _____ E-mail: _____

I would like to be placed in the IOMS referral database. Please mark which address you would like in a published directory and website. Home Work

Hospital or Clinic Affiliations: _____

Type of Practice (ex. FP, EM, OMT, etc.): _____ Fellowships: _____

AOA Member: Yes No AOA Member Number: _____ IL License Date: _____ Number: _____

Osteopathic College: _____ Graduation Year: _____

Osteopathic National Boards (Year Passed): _____ or Not Taken USMLE (Year Passed): _____ or Not Taken

Board Certification (most recent renewal date): _____ Original Certification Date: _____ or Not Taken

If accepted for membership I agree to comply with the IOMS Bylaws and with the AOA Code of Ethics. By my signature, I authorize release of the information contained in this application and in membership files of those organizations and hospitals to whom I may subsequently apply for membership; and the release to IOMS by organizations and hospitals of information relative to my previous membership in those organizations. I am a resident or a licensed physician in compliance with the state board of medical licensure and/or discipline's order.

Signature: _____ Date: _____

Please explain lapses between training and practice on the other side of this form or on an attached document

MEMBERSHIP CATEGORY:

Active (\$400) 3rd Year in Practice (\$200) 2nd Year in Practice (\$120) 1st Year in Practice (\$40) Associate (\$50)
 Retired (\$40) Postgraduate (\$20) Student (\$0) Professional (\$400)

Were you referred by a IOMS member? Yes No. If yes, please list _____

Amount \$ _____ Enclosed is my check Please charge my: VISA MasterCard

Card Number: _____ Expiration Date: _____

Signature: _____ Date: _____

Please mail to the: Illinois Osteopathic Medical Society, 142 E. Ontario Street, Chicago, IL 60611

Phone: 800-621-1773 ext 8174 • Fax: 312-202-8224 • e-mail ioms@ioms.org