



MEMBERSHIP RENEWAL / APPLICATION

Thru April 30, 2019

First Name: _____ Middle Name/Initial: _____ Last Name: _____		
Designation: _____		AOA Member Number: _____
Preferred Contact by NYSOMS: <input type="checkbox"/> Work <input type="checkbox"/> Home		

Home	Work
Address 1: _____	Address 1: _____
Address 2: _____	Address 2: _____
City: _____	City: _____
State: _____ Zip: _____ County _____	State: _____ Zip: _____ County _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____
Cell Phone: _____	Website: _____
Email: _____	

Has your license ever been suspended or revoked? Yes No? (If yes, please provide details separately.)

Have you ever been convicted of a felony offense? Yes No? (If yes, please provide details separately.)

If accepted for membership I agree to abide by the Code of Ethics and the Constitution and Bylaws of NYSOMS. By submission of this document, I authorize release of the information contained herein and in membership files of those organizations and hospitals to whom I may subsequently apply for membership; and the release to NYSOMS by organizations and hospitals of information relative to my previous membership in those organizations. If I am a resident physician or a licensed physician, I am in compliance with the state board of medical licensure.

Signature: _____ Date: _____

If you were referred by a NYSOMS member, please list: _____

MEMBERSHIP CATEGORY:

ACTIVE First Year \$50 ACTIVE Second Year \$100 ACTIVE (all others) \$200

Federally Employed DO (working in NYS not licensed in NYS) \$200

Retired (dues waived)

Associate membership \$50 (Related Professional)

Interns / Residents/ Fellows (dues waived) Required: Program: Intern__ Residency__ Fellowship__ PGY__

Program Hospital: _____ Specialty: _____ Expected Completion Date: _____

Enclosed is my check (Payable to: **NYSOMS**) or Charge: VISA MasterCard AMEX DISCOVER

Card Number: _____ Expiration Date: _____

Mail to: NYSOMS, 1855 Broadway, New York, NY 10023 OR Fax (Charge card only) to: (212) 261-1786

Please note for tax purposes that the New York State Osteopathic Medical Society (NYSOMS) membership dues may be deductible as a business expense. NYSOMS estimates that 12 % of your membership dues is used for the NYSOMS' lobbying activities and is therefore not deductible for income tax purposes. We suggest that you retain a copy of this statement for your records and consult with your tax advisor.

I would like to become more involved in the New York Osteopathic Medical Society.

Please consider me for the following committee(s):

- | | |
|--|---|
| <input type="checkbox"/> Awards | <input type="checkbox"/> Legislation |
| <input type="checkbox"/> Bylaws | <input type="checkbox"/> Membership |
| <input type="checkbox"/> Convention | <input type="checkbox"/> Nominations |
| <input type="checkbox"/> Ethics | <input type="checkbox"/> CME Programs |
| <input type="checkbox"/> Finance | <input type="checkbox"/> Public Relations |
| <input type="checkbox"/> Medical Practice | <input type="checkbox"/> Scholarship |
| <input type="checkbox"/> Mentor to Student | <input type="checkbox"/> Young Physicians |

I am interested in providing:

CME Course. Give details _____

Organize a local meeting and/or CME program. Give details _____

Indicate other ways you would like to get more involved in NYSOMS activities:

I currently serve on the following professional board(s) and/or panel(s):

_____ Term: _____

_____ Term: _____

_____ Term: _____

Other comments:

Thank you!

Membership Committee Recommendation: