



MEMBERSHIP RENEWAL / APPLICATION

May 1, 2011- April 30, 2012

First Name: _____ Middle Name/Initial: _____ Last Name: _____

Designation: DO Additional-Specify: _____ AOA Member Number: _____

Preferred Contact by NYSOMS: Work Home

Listing in NYSOMS member directory: Work Home (Work contact will be used if none indicated)

Contact Information

Home

Address 1: _____

Address 2: _____

City: _____

State: _____ Zip: _____ County _____

Telephone: _____

Fax: _____

Cell Phone: _____

Primary Email: _____

Work

Address 1: _____

Address 2: _____

City: _____

State: _____ Zip: _____ County _____

Telephone: _____

Fax: _____

Website: _____

Hospital or Clinic Affiliations: _____

_____ Practice Primary Focus (ex. FP, EM, OMT, etc.): _____ Secondary Focus: _____

_____ Exclude me from the physician referral program _____ Exclude me from the mentor program

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

Retired (dues waived)

Associate membership \$50 (Out of State Osteopathic Physician or 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.

Questions: Phone: 800-841-4131

e-mail: info@nysoms.org

Website: www.nysoms.org