



NYSOMS MEMBERSHIP APPLICATION

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

Designation: _____ NYS License #: _____ AOA#: _____

Preferred Contact by NYSOMS: _____ Office _____ Home

<p>HOME:</p> <p>Address 1: _____</p> <p>Address 2: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Telephone: _____</p> <p>Cell Phone: _____</p> <p>Email: _____</p> <p>Med School: _____</p>	<p>OFFICE:</p> <p>Address 1: _____</p> <p>Address 2: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Telephone: _____</p> <p>Work Fax: _____</p> <p>Website: _____</p> <p>Second Office Location: add on back or separate sheet</p>
<p>Graduation Date (or expected): _____</p>	
<p>Primary Specialty:</p> <p>Secondary Specialty:</p> <p>Board Certification(s):</p> <p>Fellowships:</p> <p>Licensed to Practice Medicine (States):</p>	<p>Academic Position:</p> <p>Organization:</p> <p>Title:</p> <p>Dept:</p> <p>Hospital Affiliations:</p>
<p>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 20% 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.</p>	

I have complied with the laws regarding the practice of osteopathic medicine in the state where I now reside. Yes No
 If no, explain: _____

Has your license ever been suspended or revoked? Yes No
 If yes, explain: _____

Have you ever been convicted of a felony? Yes No
 If yes, explain: _____

If I am accepted as a member of the New York State Osteopathic Medical Society, I promise to comply with its Constitution, Bylaws and the principles embodied in its Code of Ethics. (Bylaws can be forwarded upon request by member) _____ **Check here to accept**

Signature: _____ **Date:** _____

Select Membership type: ACTIVE D.O. (2+ yrs in practice)(\$200) _____ 2nd Year in Practice D.O.(\$100) _____
 1st Year in Practice D.O.(\$50) _____ Associate MD/PHD (\$50)(Teaching, research, admin or exec employees of COM or affiliated hospital) _____ Postgraduate D.O.(Free) _____ Student D.O.(Free) _____

Enclosed is my check _____ (payable to: NYSOMS) OR Charge my: _____ VISA _____ MasterCard _____ AMEX _____ Discover
 Card Number: _____ Expiration Date: _____ CVV: _____

Questions? Phone: (212) 261-1784 email: nysoms@nysoms.org Website: www.nysoms.org

Please mail to: NYSOMS, PO BOX 8000, Old Westbury, NY 11568 or FAX: (516) 686-3767

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

Please consider me for the following committee(s):

- | | | |
|----------------------|------------------|----------------------|
| ___ Awards | ___ Legislation | ___ Young Physician |
| ___ Bylaws | ___ Convention | ___ Public Relations |
| ___ Ethics | ___ Finance | ___ Scholarship |
| ___ Medical Practice | ___ Membership | |
| ___ Nominations | ___ CME Programs | |

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!