NYSOMS MEMBERSHIP APPLICATION

First Name:____________________________ Middle Name/Initial: ____________ Last Name:______________________________

Designation:__________________________ NYS License #: __________________ AOA#:_________________

Preferred Contact by NYSOMS: _______ Office ________Home

HOME: Address 1:___________________________________ Address 2:___________________________________ City:__________________State:_____Zip:_________ Telephone:__________________________________ Cell Phone:_________________________________ Email:______________________________________ **Med School:**__________________________________	**OFFICE:** Address 1:___________________________________ Address 2:___________________________________ City:__________________State:___ Zip:________ Telephone:__________________________________ Work Fax:___________________________________ Website: ___________________________________ Second Office Location: **add on back or separate sheet**
Graduation Date (or expected): _______________________	
Primary Specialty: **Secondary Specialty**: **Board Certification(s)**: **Fellowships:** **Licensed to Practice Medicine (States):**	**Academic Position:** **Organization:** **Title:** **Dept:** **Hospital Affiliations:**

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.

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 (2+ yrs in practice)($200) ______ 2nd Yr in Practice($100)________ 1st Yr in Practice($50)________
ASSOCIATE (Teaching, research, admin or exec employees)_______ Postgraduate(FREE)_______ Student(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________________________

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

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

____ Term:________

____ Term:________

____ Term:________

Other comments:

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Thank you!