MEMBERSHIP RENEWAL / APPLICATION

May 1, 2019 - April 30, 2020

First Name:_____ Middle Name/Initial:_____Last Name: _____

Designation: _____ AOA Member Number: _____

Preferred Contact by NYSOMS: ___ Work ___Home

Home

Address 1: _____

Address 2: _____

City:_____

State:____ Zip:_____County_____

Telephone:_____

Fax:_____

Cell Phone:_____

Email:_____

Work

Address 1: _____

Address 2: _____

City:_____

State:____ Zip:_____County_____

Telephone:_____

Fax:_____

Website:_____

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 you referred by a NYSOMS member, please list: _____

MEMBERSHIP CATEGORY:

___ACTIVE First Year in Practice $50 ___ACTIVE Second Year in Practice $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:**NYSOMS** @ NYCOMEC, NYIT de Seversky Mansion, Room 107, Old Westbury, NY 11568 **OR** Fax to: 516-686-3767

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.

Questions: Phone: 800-841-4131 e-mail: nysoms@nysoms.org Website: www.nysoms.org

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

Please consider me for the following committee(s):

____Awards
____Bylaws
____Convention
____Ethics
____Finance
____Medical Practice
____Mentor to Student
____Legislation
____Membership
____Nominations
____CME Programs
____Public Relations
____Scholarship
____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: