MEMBERSHIP REGISTRATION

Membership Year: **2019** AOA#:_____

Nickname:_____ Credentials: (ex: DO, OMS-I): _____

Full Name:_____

Street Address: _____

City/State/Zip:_____

Phone:_____ Cell:_____

Fax:_____ Email:_____

Medical School:_____ Grad. Year: _____

Level of Membership:

○ Regular Active Membership	$200.00
○ Active Military	$100.00
○ Student/Resident	$0
Pro-Rated (1st 3 years of practice upon completion of residency)	
○ First Year Active Practice - 25%	$50.00
○ Second Year Active Practice - 50%	$100.00
○ Third Year Active Practice - 75%	$150.00
○ Retired (Retirement Date:_____)	$75.00
○ Non-Resident (State:_____)	$100.00

Acceptable forms of payment: Check or credit card.

Check #:_____ Date:_____

Credit Card: ☐MC ☐Visa ☐Discover ☐ American Express

Card Number:_____ Expiration Date: _____

Complete and return this form with payment to:
Alabama Osteopathic Medical Association
PO Box 51928 Knoxville, TN 37950
Email: jamie@aloma.org Website: www.aloma.org
Phone: (205) 570-5576 Fax: (205) 206-7664(credit card registrations only)