



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

AMERICAN OSTEOPATHIC ASSOCIATION

APPLICATION FOR ASSOCIATE MEMBERSHIP

Associate Membership in the American Osteopathic Association (AOA) is limited to those individuals who have a professional relationship with an AOA member and/or with affiliates of this Association as specified in the **Bylaws**.

Application for membership and payment of any fees should not be construed as acceptance as an Associate Member. The Bureau of Membership reviews all applications for membership and provides appropriate recommendations to the Board of Trustees for action. The Board of Trustees has the final authority in approval of any membership request.

Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____-_____

Current Employer: _____

Current Position: _____

Current Email: _____

Reason for seeking Associate Membership:

- Non-DO faculty member in an AOA-accredited college or training program
- Administrative employee of an AOA-approved medical institution
- Administrative employee of an AOA-affiliate organization
- Doctor of Medicine (MD), Dentistry or Podiatry in practice with a DO member
- Other: _____ Please Specify: _____

I hereby make application for Associate Membership in the American Osteopathic Association and request consideration by the AOA Bureau of Membership and the Board of Trustees. Enclosed with my application is a current curriculum vita or resume outlining my professional accomplishments, an endorsement by a DO member of the Association, and the membership fee of \$99.00. It is understood that Associate Membership may be withdrawn upon failure to pay annual dues or meet the qualifications for membership as denoted in the **Bylaws**.

Signature of Applicant: _____ Date: _____



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ENDORSEMENT BY DO

I endorse _____ as a candidate for Associate Membership in the American Osteopathic Association as an individual who supports the goals and objectives of this Association.

Name: _____ Title: _____

Signature: _____ Date: _____

Please submit your check or credit card payment for \$99.00

My Check is enclosed

Please make checks payable to: American Osteopathic Association

Please charge my: MasterCard Discover Visa American Express

Card Number: _____ Exp. Date: _____

Signature: _____ Amount: _____

PLEASE ATTACH CURRICULUM VITAE OR RESUME TO APPLICATION.

Return to:

American Osteopathic Association

Member Service Center

142 E. Ontario Street

Chicago, IL 60611-9961

Phone: 1-800-621-1773, press "1"

Fax: (312) 202-8206

American Osteopathic Association Associate Membership Bylaws

By specific action of the Board of Trustees, or its executive committee, associate memberships may be granted to the following:

Graduates of accredited school of medicine, dentistry or podiatry holding teaching, research or administrative positions in AOA approved hospitals and colleges or who practice jointly with regular members of this association;

Doctors of philosophy or education and other non-doctoral personnel holding teaching, research or administrative positions in AOA accredited hospitals or colleges;

Administrative employees of this Association, affiliated organizations and divisional societies; and

Any other professionals as determined by the Board of Trustees, excepting doctors of osteopathy and students in osteopathic colleges.

Such associate members shall be required to pay dues and assessments as determined by these bylaws. They shall receive a complimentary subscription to the Association's publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

Associate members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Associate members will have special listing in the AOA's ***Online Directory of the Profession***.