



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

APPLICATION FOR INTERNATIONAL PHYSICIAN MEMBERSHIP

International Physician Membership in the American Osteopathic Association (AOA) is limited to those MDs who are graduates of schools of medicine located outside of the US on an official list of schools recognized by the AOA, holding a license for unlimited scope of medical practice including the authority to prescribe without limitation in their country of practice, and reside and practice outside the US and support the goals and objectives of the AOA and agree to subscribe to its code of ethics. Application for membership and payment of any fees should not be construed as acceptance into International Physician Membership status. The AOA Bureau of Membership reviews 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.

1. Your Information

Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____ E-mail: _____

Current Employer: _____

Current Position: _____

Current Email: _____

2. Reason for Seeking International Physician Membership

3. Statement of Application

I hereby make application for International Physician Membership in the American Osteopathic Association and request consideration by the Bureau of Membership and the Board of Trustees. Enclosed with my application is payment of the current annual membership fee of \$441.00. It is understood that International Physician Membership may be withdrawn upon failure to pay annual dues or meet the qualifications for membership as denoted in the AOA's Bylaws. I further agree to comply with the AOA's Code of Ethics.

Signature of Applicant: _____ Date: _____

4. Dues Payment

Please submit your check or credit card payment for \$441.00 (in US currency), the current annual dues rate for International Physician Membership in the AOA.

My certified or cashier's check made payable to the American Osteopathic Association is enclosed.

Please charge my: American Express Discover MasterCard Visa

Card Number: _____ Exp. Date: _____

Signature: _____ Amount: _____

5. Return

Please complete and return this application to the address of fax number below with:

- a copy of your medical license valid in the country or region in which you practice, translated into English by an officially certified language translator; and
- an original document that attests to the fact that you are a graduate of a medical institution listed in the Directory of the World Health Organization.

American Osteopathic Association
Department of Membership
142 E. Ontario St.
Chicago, IL 60611-9961

Fax: (312) 202-8206

Please contact the AOA's Member Service Center if you have any questions: 1-800-621-1773, press "1"