POMA PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION

# MEMBERSHIP APPLICATION

## PERSONAL INFORMATION

**NAME:** _____ **AOA#** _____

**OFFICE ADDRESS:** _____ **HOME ADDRESS:** _____

_____ _____

_____ _____

**(PH)** _____ **(PH)** _____

**EMAIL:** _____ **PHONE:** _____

**DATE OF BIRTH:** _____

If I am accepted as a member of the Pennsylvania Osteopathic Medical Association, I promise to comply with its Constitutions, Bylaws and the principals embodied in its Code of Ethics.

**SIGNATURE**: _____ D**ATE**_____

PAYMENT: CHECK or CREDIT CARD

CREDIT CARD #: _____

EXPIRATION DATE: _____ CVV: _____

BILLING ADDRESS: HOME or OFFICE (if other please fill below)

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| MEMBERSHIP TYPE* | MEMBERS FEES |
|---|---|
| ACTIVE | $ 425 |
| OUT OF STATE | $ 150 |
| ASSOCIATE (Non-osteopathic Physician) | $ 225 |

RETURN TO: POMA c/o Membership • 1330 Eisenhower Blvd. • Harrisburg, PA 17111 • PH (717) 939-9318
Membership@POMA.org • FAX (717) 939-7255
*Membership eligibilities will be verified by POMA Staff. Membership expires June 30, 2024