

**PERSONAL INFORMATION**

NAME: _____ AOA#: _____
 DATE OF BIRTH: _____ COM/GRAD YEAR: _____
 OFFICE ADDRESS: _____ HOME ADDRESS: _____

 OFFICE EMAIL: _____ HOME EMAIL: _____
 OFFICE PHONE: _____ HOME PHONE: _____
 MOBILE PHONE: _____

PREFERRED METHOD OF COMMUNICATION (select up to 2):

Home Email Work Email Text Home Mail Work Mail

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: _____ DATE: _____

METHOD OF PAYMENT: CREDIT CARD (Visa, Mastercard, AmEx, Discover) CHECK (payable to "POMA")

CREDIT CARD: _____

EXPIRATION DATE: _____ CVV: _____

NAME ON CARD: _____

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

POMA Membership Year: June 1, 2023 – June 30, 2024

POMA MEMBERSHIP TYPE*	MEMBER FEES
ACTIVE	\$ 375
OUT OF STATE	\$ 150
ASSOCIATE (Non-osteopathic Physician)	\$ 225
RESIDENT – PGY 1	\$ 25
RESIDENT – PGY 2-4	\$ 50

RETURN TO:

POMA c/o Membership

1330 Eisenhower Boulevard, Harrisburg, PA 17111

Email: membership@poma.org | Fax: (717) 939-7255 | Phone: (717) 939-9318

*Membership eligibilities will be verified by POMA Staff. Membership expires June 30, 2024.