

## MEMBERSHIP INFORMATION UPDATE



Please Type or Print Clearly  
(Will be returned if not legible)

**Name** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_  
**Address of Current Practice or Training** \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip) (County)  
**Residential Address** \_\_\_\_\_ **Phone ( )** \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip) (County)

Whenever possible email will be used for communication. When communication is by regular mail, please send to

\_\_\_\_\_ Practice/Training \_\_\_\_\_ Residence

AOA# \_\_\_\_\_ Congressional District # \_\_\_\_\_ Legislative District # \_\_\_\_\_  
Birthdate \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Email \_\_\_\_\_ Fax \_\_\_\_\_

### Training Information Update

Internship Program \_\_\_\_\_  
Date of Completion \_\_\_\_\_  
Residency Program \_\_\_\_\_  
Date of Completion \_\_\_\_\_

### Certification Update

Specialty \_\_\_\_\_ \_\_\_ Certified \_\_\_ Eligible

Certifying Board(s) (Attach copy of certification(s))

\_\_\_\_\_  
\_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

Return to W.O.M.A. / PO Box 16486 / Seattle, WA 98116 / (206) 937-5358 / Fax (206) 933-6529