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()Mailing

()Roster

()Board Approval

Date of Application

MEMBERSHIP STATUS CHANGE REQUEST



Please Type

County City (State (Zip	Address of Current Phone () County) (City) (State) (Zip) Permanent Resident Address (County) (City) (State) (Zip) County (City)		(Applications will be returned if not legible)					
ddress of Current ractice (County) (City) (State) (Zip) ermanent Resident ddress (County) (City) (State) (Zip) OA# Congressional District # Legislative District # irrthdate Spouse's Name ender Female Male Training Pre-Medical College Year Osteopathic Medical College Year Residency (specialty & location) Years—Residency (specialty & location) Years—Specialty (OCert. (Explosional District) Year Specialty (OCert. (Explosional District) Year Year Specialty (OCert. (Explosional District) Year Year Specialty (OCert. (Explosional District) Year Year Year Year Year Year Year Year	ddress of Current ractice (County) (City) (State) (Zip) ermanent Resident ddress (County) (City) (State) (Zip) OA#					_ Phone ()		
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Certifying Board Plese consider my request to change my WOMA membership status from	Certifying Board Plese consider my request to change my WOMA membership status from	*						
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to for the following reason(s):	to for the following reason(s):	Fellowship at Specialty Certifying Board Plese consider m	y request to change my WC	DMA membership stat	tus from	-()Cert.	Years ()Eli	
		to		for the follow	ving reason(s):			

Applicant Signature