( )Accounting
( )Mailing
( )Roster
( )Board Approval

MEMBERSHIP STATUS CHANGE REQUEST

WASHINGTON OSTEOPATHIC MEDICAL ASSOCIATION
WOMA

Date of Application _____

Please Type
(Applications will be returned if not legible)

Name _____ Phone ( ) _____
Mailing Address _____

_____
(County)   (City)   (State)   (Zip)

Address of Current
Practice _____ Phone ( ) _____

_____
(County)   (City)   (State)   (Zip)

Permanent Resident
Address _____ Phone ( ) _____

_____
(County)   (City)   (State)   (Zip)

AOA# _____ Congressional District # _____ Legislative District # _____
Birthdate _____ Spouse's Name _____
Gender _____Female _____Male

Training

Pre-Medical College _____ Degree _____ Year_____
Osteopathic Medical College _____ Year_____
Internship at _____ Year_____
Residency (specialty & location) _____ Years_____
Fellowship at _____ Years _____
Specialty _____ ( )Cert.   ( )Elig.
Certifying Board _____

Plese consider my request to change my WOMA membership status from _____
to _____ **for the following reason(s):** _____

_____

_____

_____

_____

_____

_____
Applicant Signature

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

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