MEMBERSHIP STATUS CHANGE REQUEST

Date of Application ___________________

Name ____

Current Home Address ____________________________________**Phone (_____)** _______________

City, State, Zip ____**County** _____________

Address of Current Training ____

City, State, Zip ____

Preferred Mailing Address : ______ **Home** ______ **Training Program**

Preferred Email Address ____

Secondary Email Address ____

AOA # ________________ **Congressional District #** _____________ **Legislative District #** ____________

Birthdate ___________ **Gender**_________

Training

Pre-Medical College ____ Degree ___________ Year____________

Osteopathic Medical School ____ Grad Year ___________

Residency Program ____ Completion Year ___________

Practice Specialty ____ Cert._____ Elig. _____

Certifying Board ____

Please consider my request to change my WOMA membership status from ___________________________________

to _______________________________________ for the following reasons: ______________________________________

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____ ______________________________

Member Signature **Date**

Scan and send application to **hgriffin@woma.org** or submit to
PO Box 1187/Gig Harbor, WA 98335 (email preferred)

Questions? Please contact us at **425-677-3930** or you can email **executivedirector@woma.org.**