ACTIVE MEMBERSHIP APPLICATION

Date _____

Unless otherwise requested, the primary form of communication whenever possible will be email. Please print or type legibly or application will be returned. ***Attach current CV with all training, certification and past practice information.***

Name _____ Office Email _____

Physical Address of Current Practice _____ Phone _____

City, State , Zip _____ County _____

Residential Address _____ Phone _____

City, State, Zip _____ County _____

Preferred Mailing Address ☐ Office ☐ Residence ☐ Other _____

City, State, Zip _____

Gender ☐ M ☐ F AOA# _____ Birthdate _____ Spouse's Name _____

Preferred Email ☐ Office (Above) ☐ Other _____

PRACTICE INFORMATION

WA State License Number _____ Date Issued _____

Other Current/Past State Licenses _____

Present Practice Focus _____

Hospital Staff (Present) _____

Hospital Staff (Past) _____

Other State Divisional Society Memberships (Past and Present) _____

TRAINING

(If attached CV does not provide the following information, please complete below)

COM _____ Grad Year _____

Internship Program _____

Location _____ Completion Year _____

Residency Program _____

Location _____ Completion Year _____

Specialty Certification _____

Board Certification ☐ AOA ☐ ABMS Current? ☐ Yes ☐ No

Certifying Board(s) _____

_____

Have you ever had a license limited, suspended or revoked? ☐ No ☐ Yes
If yes, please attach explanation.

Have your prescribing privileges ever been limited or suspended? ☐ No ☐ Yes
If yes, please attach explanation.

Please list any interests or talents you wish to employ as a member: (Leadership, Legislative, Speaking, etc.):

_____

I will provide shadowing for premed students. I will precept osteopathic medical students

WOMA Member Referral (if known) _____

By my submission, I hereby agree to practice , comply and govern my conduct in accordance with the code of ethics of theWOMA and such other standards of conduct and practice ethics adopted by WOMA.

I hereby authorize release of the information contained in this application and WOMA membership file to those organizations or hospitals to whom I may subsequently apply for membership; and release to WOMA, by organizations, agencies and hospitals of information relative to my membership in those organizations and my professional practice. I understand that withholding or falsification of information will result in denial of membership."

Signature of Applicant_____ Date _____

Payment Options
WOMA Membership begins January 1 and ends December 31 of each year

☐ **Enclosed is my application fee of $35 and Dues of:**

☐ $160 First year in Practice (Pro-rate to $40 per remaining quarter)

☐ $320 Second year in practice (Pro-rate to $80 per remainign quarter)

☐ $640 Three or more year s in pactice (Pro-rate to $160 per remaining quarter)

☐ **Charge my $35 application fee and Dues of $** _____

☐ Visa ☐ MasterCard

Card Number _____

3-digit security code _____ Expiration Date _____ Billing Zip Code _____

Name on card, if other than applicant _____

You may complete and submit this application with your current CV to the address below or go to www.woma.org, select the Membership Tab, Join WOMA and the Active Membership Application. Type in your information, save and submit by email with your CV to hmattson@woma.org.

Please contact the WOMA office at 206-937-5358 or email kitter@woma.org if you have any questions.

P.O. Box 16486 / Seattle, WA 98116-0486
(206) 937-5358
FAX (206) 933-6529