WOMA INSTITUTIONAL MEMBERSHIP APPLICATION

Date of Application _____

Name of Institution _____

Physical Address _____

City, State, Zip _____ **County** _____

Mailing Address _____

City, State, Zip _____ **County** _____

Phone (_____) _____

Representative Name _____

Title _____ **Gender** _____

Email _____

Secondary Email _____

If other than AOA accredited, please explain relationship of institution to the osteopathic profession: _____

_____

_____

"By my signature, as the designated representative of the above-named institution, I hereby agree to read, understand and comply with all of the requirements of the Constitution and Bylaws of the Washington Osteopathic Medical Association and conduct myself in accordance with the Code of Ethics of WOMA and the American Osteopathic Association."

_____ _____

Signature of Applicant Date

If referred by WOMA member, please list : _____

Scan and send application with **$35 application fee** and **Dues of $2100** to **hgriffin@woma.org** or submit to **PO Box 1187/Gig Harbor, WA 98335** (email preferred)

Dues may be pro-rated if joining after March 31st as follows:

April 1-June 30 $1575.00 July 1-September 30 $1050.00 October 1-December 31 $525.00

Total Payment: $_____

Payment Method: Check Enclosed # _____ Visa ☐ MasterCard ☐

Card # _____ Exp. Date: _____ CVV: _____

Credit Card Billing Zip: _____ Name on Card: _____

Signature: _____

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