WOMA ACTIVE MEMBERSHIP APPLICATION

Please complete all sections ***required.**

***Name** _____

***Address of Current Practice** _____ ***Office Phone (_____)** _____

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

Home Address _____ Home Phone (_____) _____

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

***Mailing Address** ☐ Office ☐ Residence ☐ Other _____

City, State, Zip _____

***Preferred Email Address** _____

Secondary Email Address _____

***AOA #** _____ Birthdate _____ Gender_____

PRACTICE INFORMATION

WA State License Number _____ Date Issued _____

Other Current/Past State Licenses _____

Present Practice Focus _____

Practice Name _____

TRAINING

COM _____ Year _____

Residency Completed at _____ Year _____

Specialty Certification_____ Year _____

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.

☐ I am willing to have Pre-Med Students shadow me

☐ I am willing to precept 3rd and 4th year Osteopathic Medical Students

Referred by:_____

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

_____

_____

"By my signature, 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 1st and ends December 31st of each year.

***Application Fee $35 + Choose Member Type Below**

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

☐ **$320** Second Year in Practice (Pro-rate $80 per remaining quarter)

☐ **$480** Three Years in Practice (Pro-rate $120 per remaining quarter)

☐ **$640** Four or More Years in Practice (Pro-rate $160 per remaining quarter)

Total Payment: $_____

Payment Method: ☐ Check Enclosed # _____ ☐ Visa ☐ MasterCard

Card # _____ Exp. Date: _____ CVV: _____

Credit Card Billing Address: _____ City: _____ State: _____ Zip: _____

Name on Card: _____

Signature: _____

Please scan and email to **hgriffin@woma.org** or submit to the address below (email preferred)**.**

PO Box 1187 / Gig Harbor, WA 98335

425-677 3930

Questions? Please contact us at the phone number above or you can email **executivedirector@woma.org.**