WOMA POST GRADUATE MEMBERSHIP APPLICATION

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 # _____ **Birthdate** _____ **Gender**_____

Training (If not applicable, state N/A, If unknown, state Unknown)

Pre-Medical College _____ Degree _____ Year_____

Osteopathic Medical School _____ Grad Year _____

Residency Program _____ Completion Year _____

Practice Specialty _____

"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. Should I be granted membership, I promise to read, understand and comply with all the requirements of the Constitution and By-Laws of the WOMA and conduct myself and practice in accordance with the Code of Ethics of the WOMA and the American Osteopathic Association."

_____ _____

Signature of Applicant **Date**

If referred by WOMA member, please list : _____

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.**