WOMA RETIRED MEMBERSHIP APPLICATION

Please complete all sections ***required.**

***Name** ____

***Address** ______________________________ ***Phone (______)** ______________________

***City, State, Zip** ______________________________ County ______________________

***Preferred Email Address** ____

Secondary Email Address ____

AOA #______________ Congressional District # _________ Legislative District #_________

Birthdate ______________________ Gender___________________

TRAINING

Osteopathic Medical College ______________________________ Year __________

Specialty ______________________________ Cert. ______ Elig. _____

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.

PRACTICE INFORMATION

WA State License Number ______________________________ Date Issued ______________________

Other Current/Past State Licenses ____________________________Date ______________ License No. ___________________

Other State Divisional Society Memberships (Past & Present) ______________________________

Previous Practice(s) beginning with most recent, Attach a separate sheet if necessary ______________________________

____

Have you ever been a member of WOMA? If yes, attach reason for leaving: _____ Yes _____ No

"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 under-stand that withholding or falsification of information will result in denial of membership."

____ ______________________________

Signature of Applicant Date

If referred by WOMA member, please list : ____

Scan and send application with **$35 application fee** and **Dues of $60 for a total of $95** to **hgriffin@woma.org** or submit to **PO Box 1187/Gig Harbor, WA 98335** (email preferred)

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.**