POMA

PENNSYLVANIA
OSTEOPATHIC
MEDICAL
ASSOCIATION

717-939-9318
In Pa. 1-800-544-POMA
Fax 717-939-7255
e-mail poma@poma.org

POMA LIFE MEMBERSHIP QUESTIONNAIRE

(Please write legibly, please complete in full)

NAME: _____

POMA DISTRICT #: _____ OUT OF STATE MEMBERS NAME STATE: _____

HOME ADDRESS: _____

_____ PHONE: ( ) _____

AOA#: _____ DATE OF BIRTH: _____ DATE JOINED: _____

REASON: A) RETIREMENT -*Date*: _____

B) DISABILITY - *Please explain:* _____

_____

_____

DO YOU INTEND TO PRACTICE MEDICINE IN ANY CAPACITY? YES OR NO

IF YES, PLEASE SPECIFY: _____

OFFICE ADDRESS: _____

_____

PHONE: ( ) _____

DO YOU INTEND TO MAINTAIN AN ACTIVE LICENSE TO PRACTICE MEDICINE?

YES OR NO

IF YES, WHICH STATE(S)? _____

SIGNATURE _____ DATE _____

Board & Membership Department purposes only.

Approved/Denied If denied, reason listed below	Letter Sent	Certificate/Card Sent