POMA Membership Application

List of fees and payment information on reverse.

1330 Eisenhower Boulevard, Harrisburg, PA 17111 • (717) 939-9318 • Toll-free in PA (800) 544-7662
Fax (717) 939-7255 • E-mail poma@poma.org

Today's Date ______________ I hereby apply for ________ New Membership ________ Reinstatement

Personal Information

Name ______________ AOA No. ______________ SS No. ______________

Primary Office Address (for mailing) ______________

City ______________ State ________ Zip ________ Telephone (____)______________

Fax (____)______________ E-mail ______________

Residence Address ______________

City ______________ State ________ Zip ________ Telephone (____)______________

If Board Certified, List Certifying Board ______________ Date of Birth ________ Spouse's Name ______________

Undergraduate Education

College ______________ Graduation Year ________

Location ______________ Degree(s) Held ______________

Professional Education

Full Name of Osteopathic Medical College ______________ Graduation Year ________

Internship
Hospital ______________

Location ______________ Dates ______________

Residency *(use other side if needed)*
Hospital(s) ______________

Location ______________ Type of Residency ______________ Dates ______________

Fellowship
Hospital ______________ Specialty ______________

Location ______________ Dates ______________

Practice Record

Licensed in (State) ______________ Date ______________ Lic. No. ______________

Licensed in (State) ______________ Date ______________ Lic. No. ______________

I have practiced in the following location(s): *(use other side if needed)*
City ______________ State ______________ Dates ______________

City ______________ State ______________ Dates ______________

I have complied with the laws regarding the practice of osteopathic medicine in the state where I now reside.
Yes ________ No ________ If no, explain ______________

Have you ever been convicted of a felony? ______ Yes ______ No *(If yes, please explain on reverse.)*

If I am accepted as a member of the Pennsylvania Osteopathic Medical Association, I promise to comply with its Constitution, Bylaws and the principles embodied in its Code of Ethics. (Bylaws will be forwarded upon acceptance.)

Signature of Applicant ______________ Date ______________

Unless objection is raised, membership privileges will begin 30 days after applicant's name has been published in the POMA Newsletter.