



**American
Osteopathic
Academy of
Addiction
Medicine**

MEMBERSHIP APPLICATION

(PLEASE PRINT LEGIBLY)

NAME:			Title: <input type="checkbox"/> DO <input type="checkbox"/> MD <input type="checkbox"/> Other		
Contact Preference: <input type="checkbox"/> Work <input type="checkbox"/> Home		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single	
<u>WORK</u> Address:					
City:		State:	Zip:	County:	
Phone: ()		Fax: ()		Email:	
<u>HOME</u> Address:					
City:		State:	Zip:	County:	
Phone: ()		Fax: ()		Email:	
Hospital or Clinic Affiliations:					
Type of Practice (eg. FP, EM, OMT, etc):			AOA Member <input type="checkbox"/> Yes <input type="checkbox"/> No		AOA Member Number:
Do you have a CAQ in Addiction Medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No Through Which Specialty College?					
Osteopathic College/Year:			Specialty:		
Osteopathic National Boards (Year Passed)			Are you Board Eligible? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Specify which boards(s):					
Are you working with an alcohol/drug treatment program?			What type of Program?		
Do you hold an osteopathic medical school appointment? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> School/Department			Position:		
Do you work in private practice? <input type="checkbox"/> Yes <input type="checkbox"/> No			Research related to Addiction Medicine:		
State License #:					
I would be interested in volunteering on the following committee (s): <input type="checkbox"/> Membership <input type="checkbox"/> CME Program <input type="checkbox"/> Newsletter					

(OVER)

If accepted for membership, I agree to abide by the Code of Ethics and the Constitution and Bylaws of AOAAM. By submission of this document, I authorize release of the information contained in herein and in membership files of those organizations and hospitals to which I may subsequently apply for membership; and the release to AOAAM by organizations and hospitals of information relative to my previous membership in those organizations. I am a resident or a licensed physician in compliance with the state board of medical licensure and/or discipline's order.

Please attach your curriculum vitae or separate sheet listing publications and other personal information concerning your activities in addiction medicine, if available. Thank you.

Signature:

Date:

Printed Name:

Annual Membership Dues:

Active (osteopathic physician).....	\$150
Associate	\$75
Resident.....	\$50
Fellow	\$50
Intern.....	\$25
Student.....	\$25
(Student Membership dues are one time fee)	

Please make your check payable to **AOAAM**. Check #: _____

PLEASE SEND YOUR COMPLETED APPLICATION WITH YOUR PAYMENT TO:

American Osteopathic Academy of Addiction Medicine

P.O. Box 280

LaGrange, IL 60525-0280

708.572.8006

708.401.0360 - fax