American Osteopathic College of Pathologists, Inc.
2902 N. Baltimore St. Kirksville, MO 63501
Telephone: 660-665-6601 Fax: 660-627-2623
Email: mwise@aocd.org

MEMBERSHIP APPLICATION

(Please type or print)

AOA # _____ Date: _____ E-Mail Address: _____

Name: _____
First Middle Last

Preferred Mailing Address: _____
Street/P.O. Box City State Zip code

Primary Office Telephone: _____ Primary Office Fax: _____

Home/Cell Telephone: _____

Pre-Medical Education: _____
School Degree Date

Medical Education: _____
School Degree Date

Internship: _____
Hospital City, State Dates

Residency Training: _____
Hospital City, State

_____
Specialty Dates

Additional Training: _____
Location Dates

Board Eligible? Board Certified? % of practice devoted to pathology: _____

If yes, list specialty board(s) and date of certification: _____

Primary Specialty: _____ Secondary Specialty: _____

State Medical Licenses Held: _____
Give State(s) and License Number

Hospital Affiliations: _____

_____

MEMBERSHIPS/AFFILIATIONS *(You may attach a current curriculum vitae containing all information.)*

American Osteopathic Association: _____
Dates

Other Affiliations: (Give Organization Name(s) and Dates): _____

_____

_____

Other Civic, Professional and Social Affiliations: _____

_____

_____

If elected to membership, I shall abide by all the rules, regulations, Constitution and Bylaws of the American Osteopathic College of Pathologists. I shall pay all dues in a timely manner and conduct myself in an ethical way. I will also do my best to promote the welfare of the American Osteopathic College of Pathologists. I certify the above information is accurate and that I am in compliance with the regulations of the State Board of Medical Licensure.

Signed _____

If not elected to membership, all fees and photos will be returned to applicant.
Applications will be reviewed by the Board of Governors.

ANNUAL DUES: Payable for calendar year: January 1 – December 31

☐ Active $300.00 ☐ First Year in Practice $150.00 ☐ Associate $100.00 ☐ Affiliate $50.00

☐ Retired $100.00 ☐ Post Graduate $10.00 ☐ Student $0.00 ☐ Life $0.00

Please return completed application with check or credit card information made payable to the American Osteopathic College of Pathologists, Inc. or provide the requested credit card information.

☐ Visa ☐ Master Card

Credit Card #: _____

Expiration Date: _____ CVV: _____

Name appearing on card: _____ (please print)

☐ By checking this box, I authorize American Osteopathic College of Pathologists, Inc. to charge my credit/debit card in the amount selected above.

No refunds permitted for online payments. Please contact the AOCP for refund information.

RETURN APPLICATION AND PAYMENT TO:
AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, INC.

2902 N. Baltimore St.
KIRKSVILLE, MO 63501

Or

CLICK HERE TO SUBMIT BY EMAIL

Action taken: _____ Date: _____

_____
AOCP Secretary/Treasurer