



IOMS Membership Application

Please mail to: IOMS, 142 E. Ontario St., Chicago, IL 60611 · phone 800-621-1773 ext 8174 · fax 312-202-8393 · email ioms@ioms.org

NAME

DEGREE

H

CHECK YOUR PREFERRED CONTACT ADDRESS

W

HOME ADDRESS

CITY/STATE/ZIP

COUNTY

EMAIL

PHONE

FAX

WORK ADDRESS

COUNTY

CITY/STATE/ZIP

EMAIL

PHONE

FAX

HOSPITAL or CLINIC AFFILIATIONS

SPECIALTY (FP, EM, OMT, etc.)

AOA Member? Yes No

AOA ID#

IL License #

1. Do you currently have an unrestricted license to practice medicine?

Yes No

2. Has your license ever been suspended or revoked? (If yes, please provide details separately.)

Yes No

3. Have you ever been convicted of a felony offense? (If yes, please provide details separately.)

Yes No

I am applying for membership in the Illinois Osteopathic Medical Society and I agree to comply with IOMS bylaws and the AOA code of ethics.

SIGNATURE

Referred for membership by:

SELECT YOUR MEMBERSHIP CATEGORY:

- \$ 435 ACTIVE
- 245 3rd YEAR in PRACTICE
- 145 2nd YEAR in PRACTICE
- 50 1st YEAR in PRACTICE
- 55 ASSOCIATE
- 44 RETIRED
- 25 POSTGRADUATE
- 0 STUDENT
- 435 PROFESSIONAL

PAYMENT

- VISA MasterCard
- AmEx Discover

Check # _____

CARD NUMBER

SECURITY CODE

EXPIRATION DATE

SIGNATURE