AMERICAN OSTEOPATHIC ACADEMY OF SPORTS MEDICINE

Membership Application - January 1 through December 31

Full Name: ____________________ **Suffix:** ________ **Birth Date (optional):** ________ **Gender (optional):** ____________

Institution: ____

Street Address or PO Box #: ____

City: ____________________ **State/Province:** ____________________ **Zip/Postal Code:** ____________________

Phone: ____________________ **Fax:** ____________________ **Mailing Address:** ❒ Work ❒ Home

Email: ____________________ **AOA #:** ____________________ **BOC #:** ____________________

Membership Directory (required):
❒ Yes, please include my information in the online directory.
❒ No, I waive my directory listing benefit.

I am a team physician for the following sports teams:
(check all that apply)

❒ Youth Sports
❒ High School
❒ College
❒ Professional
❒ Special Olympics
❒ USA Team
❒ Olympic Coverage

Please list the teams you cover: ____

____

What percentage of your practice is related to sports medicine?:
❒ 1%-25% ❒ 26%-50% ❒ 51%-75% ❒ 75%-100%

Do you practice in a sports medicine clinic?: ❒ Part Time ❒ Full Time

Years of Practice in Sports Medicine: ____________________

Name of Medical School: ____________________

Date of Graduation: ____________________

Residency Completed At: ____________________

Date of Completion: ____________________

Primary Board Certification: ____________________
❒ DO ❒ MD

Sports Medicine Fellowship Site: ____________________

Date of Completion: ____________________

Do You Have a CAQ in Sports Medicine?:
❒ Yes ❒ No

❒ **I did not complete a sports medicine fellowship**

All membership categories receive an online subscription to the journal.

<u>Membership Categories:</u>

Physician ❒ $320

Early Career ❒ $220
This rate is available to members within one year of their fellowship graduation date.

International ❒ $200
Qualified members must reside and practice outside of the United States.

Associate Member ❒ $295
PhD, PA, ATC, PT

Fellow ❒ $200
Currently participating in a Sports Medicine Fellowship.

Resident/Intern ❒ $200
Provide proof of residency/internship.

Lifetime ❒ $100
Qualified members must be pre-approved by the Board.

Student
Please check years left until graduation.
❒ 1 year ($0) ❒ 2 years ($0) ❒ 3 years ($0) ❒ 4 years ($0)

❒ I would like to add a print subscription of the journal for $50/year.

Payment Total:
❒ Check payable to AOASM, US funds only, drawn on a US bank
❒ Visa/MasterCard/American Express

Name of Cardholder: ____________________

Card Number: ____________________

Expiration Date: ____________________ **CVV:** ____________________

Signature of Cardholder: ____________________

Please send completed form, payment, & proof of residency/internship or student status (if applicable) to:
• AOASM • 2424 American Lane • Madison, WI 53704-3102 • Phone: +1-608-443-2477 • Fax: +1-608-333-0310 • Web: www.aoasm.org • Email: info@aoasm.org •