



Colorado Society of Osteopathic Medicine Membership Application

(PLEASE TYPE OR PRINT CLEARLY)

Board Action _____

(Please complete as much information as possible)

Name: _____ (first) (middle) (last)
Office Address: _____ (city) (state/zip)
Phone: _____ Fax: _____ Email _____
Residence: _____ Phone: _____ (city) (state/zip)
AOA#: _____ Colorado License #: _____ Male Female
Date of Birth: _____ Marital Status: _____ Spouse Name: _____
Preferred mailing address: Office Home

Practice Status (Please complete as much information as possible)

Please check one:	Private Practice	Resident/Fellow	Intern	Student
	Faculty or Hospital	Military	Academic Faculty	
Liability Insurance	_____			
Osteopathic Medical School:	_____	Completed:	_____	
Internship:	_____	Completed:	_____	
Residency:	_____	Completed:	_____	
Fellowship:	_____	Completed:	_____	
Year Started Practice:	_____	Specialty:	_____	Certification Year: _____
	Use OMT	Osteopathic Board	Allopathic Board	
Other Professional Degrees:	_____			
Current Hospital Affiliation(s):	_____			
Previous State Osteopathic Associations:	_____			
Previous Practice Locations:	_____			

By my signature, I authorize release of the information contained in this application and membership file to those organizations or hospitals to whom I may subsequently apply for membership, and the release to CSOM by organizations and hospitals of information relative to my membership in those organizations.

I agree to practice, comply, and govern my conduct in accordance with the Code of Ethics of CSOM and AOA and such other standards of conduct and practice ethics adopted by the Society.

Signature _____ Date _____

➔ See other side for dues schedule. ➔

CSOM Dues

<i>Regular member</i>	\$395.00
<i>2nd year in practice after residency</i>	\$160.00
<i>1st year in practice after residency</i>	\$ 80.00
<i>Part-time (must provide proof from insurer)</i>	\$225.00

<i>Retired or Military</i>	\$75.00
<i>Associate member (out-of-state)</i>	\$295.00
<i>Academic member (intern, resident, fellow)</i>	Complimentary

<i>Denver Regional Osteopathic Medical Society</i>	\$25.00
<i>Advocates of CSOM</i>	\$25.00

Name of Advocate Member _____

Mailing Address _____ City _____ State _____ Zip _____

Phone Number _____ Email Address _____

Would you like to be contacted about serving on a CSOM Committee?

By-laws Membership Legislative CME Public Awareness

Payment Method:

Check Visa MC AMEX Check Number: _____

Credit Card Number: _____ Expiration Date: _____

Name on Credit Card: _____ Signature: _____
(Please Print)

Have You Reviewed our Member Benefits? See the Link on our Website! Check them out!!

Return completed application with recent photograph and CV to CSOM

For questions, please write or call:

Colorado Society of Osteopathic Medicine
C/O RVU-COM, 8401 S. Chambers Rd.
Parker, CO 80134

Phone: 303-322-1752 Fax: 303-322-1956
www.ColoradoDO.org