

**BROWARD COUNTY OSTEOPATHIC MEDICAL ASSOCIATION**

**DISTRICT 6-Florida Osteopathic Medical Association**

**MEMBERSHIP APPLICATION**



BROWARD ♦ FOMA 6

Please indicate membership type by placing an "X" in the box to the left of the category

P.O. Box 2294  
Hollywood, FL 33022  
Phone: (954) 792-6011  
Fax: (954) 926-3625  
www:bcoma.org

<u>Membership Category</u>	<u>Dues Rate</u>
<input type="checkbox"/> Active	\$150.00
<input type="checkbox"/> Faculty (1/2 Dues)	\$ 75.00
<input type="checkbox"/> 2 <sup>nd</sup> Year Practice	\$150.00
<input type="checkbox"/> First Year Practice	No Fee
<input type="checkbox"/> Resident	No Fee
<input type="checkbox"/> Intern	No Fee
<input type="checkbox"/> Student	No Fee
<input type="checkbox"/> Inactive (Retired)	No Fee

**INSTRUCTIONS TO APPLICANT:**

Please print or type requested information in space provided. Please complete application in its entirety. If the answer is "no", "none" or "not applicable", please indicate. If additional space is required, attach a properly identified addendum.

**PERSONAL INFORMATION**

AOA # \_\_\_\_\_ FL LICENSE #: \_\_\_\_\_ DATE : \_\_\_\_\_

FULL NAME \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS# : \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

PARTNER'S NAME: \_\_\_\_\_

Please check box to the left of the address you would prefer to receive BCOMA mailings

OFFICE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**PRACTICE HISTORY**

Please include and state any revocations of license or privilege.

PREVIOUS PRACTICE (if any): \_\_\_\_\_

HOSPITAL STAFF (present) \_\_\_\_\_

OTHER STATE LICENCE(S): STATE: \_\_\_\_\_ LICENSE # \_\_\_\_\_ DATE: \_\_\_\_\_

STATE: \_\_\_\_\_ LICENSE #: \_\_\_\_\_ DATE: \_\_\_\_\_

**EDUCATION**

**PRE-OSTEOPATHIC TRAINING**

COLLEGE: \_\_\_\_\_

DEGREE: \_\_\_\_\_ YEAR \_\_\_\_\_

**OSTEOPATHIC TRAINING**

COLLEGE: \_\_\_\_\_

DEGREE: \_\_\_\_\_ YEAR: \_\_\_\_\_

**INTERNSHIP PRORAM**

HOSPITAL: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE \_\_\_\_\_

DATES: FROM \_\_\_\_\_ TO \_\_\_\_\_

**RESIDENCY PROGRAM**

HOSPITAL: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

DATES : FROM: \_\_\_\_\_ TO: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

**CERTIFICATION: \*\* (must include copy of certificate with application)**

CERTIFYING BOARD: \_\_\_\_\_ DATE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

CERTIFYING BOARD: \_\_\_\_\_ DATE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

**DISCIPLINARY HISTORY**

Have you ever been suspended, censored, disciplined or disqualified by any licensing or regulatory agency, professional association or society? (Circle response)

YES NO IF YES, pleased give details on a separate sheet of paper.

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime in any jurisdiction other than a minor traffic offense? (Circle response)

YES NO IF YES, pleased give details on a separate sheet of paper.

Have you ever been denied, or surrendered a DEA registration or received a notice of administrative hearing from the DEA? (Circle response)

YES NO IF YES, pleased give details on a separate sheet of paper

By my signature, I herby agree to practice, comply, and govern my conduct in accordance with the code of ethics of the BCOMA and such other standards of conduct and practice ethics adopted by the Association and make application for membership in the BCOMA.

I hereby authorize release of the information contained in this application and membership file to those organizations or hospitals to which I may subsequently apply for membership and the release to BCOMA by organizations and hospitals off information relative to my previous membership in those organizations.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRED BY: (If applicable): \_\_\_\_\_ DATE: \_\_\_\_\_

**PAYMENT INFORMATION:**

Enclosed is payment in the amount of \$\_\_\_\_\_ for BCOMA membership dues. It is understood that this amount is to be returned if the BCOMA Board of Governors does not approve the application.

**ADDITIONAL INSTRUCTIONS:** To complete the processing of your application the following items are requested:

- 1) Recent photograph
- 2) Copy of your current Florida license
- 3) Copy of your certification certificate

Mail completed application with payment to:  
BCOMA – P.O. BOX 2294, HOLLYWOOD, FL 33022 (Phone: 954-792-6011)