

MAOP Membership Form

Membership Year: 2010

- Check Membership Type:** Joint Physician Member in both MAOP and MedChi (\$625)**
(See insert for description) MAOP Physician (\$225)
 MAOP Military Physician (\$145)
 MAOP Retired Physician (\$75)
 MAOP Resident (\$25)
 MAOP Student (no fee for student membership)
 MAOP Associate (\$145)

**Save \$100 and join both MAOP and MedChi (MedChi active dues are \$500/year). MAOP will submit your membership application with payment to MedChi. If you have already paid MedChi 2009 dues, remit balance of \$125 to be a joint member for 2009.

Member Information Birthdate: _____ Gender*: _____ Military rank: _____

Name*: _____

Work Address*: _____ Work Phone*: _____

_____ Work Fax: _____

_____ E-Mail: _____

Mailing Address: _____ Home Phone: _____

_____ Is your mailing address your home address?

Yes No

Professional Information AOA #: _____ Maryland License #: _____

Medical School*: _____ Year Graduated*: _____

Board Certification*: _____

Hospital Affiliation*: _____

Specialty*: _____

Do you offer OMT*? Yes No If yes, percent of practice involving OMT: _____

Employment Type: Solo Practice Two-Physician Practice Hospital Employee City/State/County Employee Group Practice HMO Employee Retired Federal Employee (indicate branch of service): _____

Practice Type: Direct Patient Care Administration Medical Research Intern Resident Retired Other: _____

Can we provide your name to current and prospective osteopathic medical students as a contact for information about the profession or as a resource for rotation/internship/preceptorship opportunities?* Yes No

Are you available as a lecturer for MAOP's Speakers Bureau? Yes No

If yes, on what topic(s) would you like to speak? _____

* I understand that MAOP maintains all information provided by members in the MAOP database and MAOP may provide to the public that information which is marked with an asterisk. I have read and agree to these MAOP policies and I attest that the information on this membership form is accurate to the best of my knowledge.

Signature: _____ Date: _____

The MAOP dues year is January 1st - December 31st.
RETURN THIS FORM with your payment. Please see enclosed invoice for payment information.

For questions, please call: 410-683-8100 or 1-888-741-6267 (MAOP)