

# MAOP Membership Form

Membership Year: 2008

- Check Membership Type:**  Joint Physician Member in both MAOP and MedChi (\$625)\*\*  
(See insert for description)  First-Time MAOP Physician Member(\$95) join by 3/31/08 to qualify  
 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 2008 dues, remit balance of \$125 to be a joint member for 2008.

**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): \_\_\_\_\_

(check box)

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

(check box)

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)