



NEVADA OSTEOPATHIC MEDICAL ASSOCIATION

MEMBERSHIP APPLICATION

P.O. Box 90601 ~ Henderson, NV 89009-0601

(702) 434-7112 ~ Fax (702) 434-7110

nvoma@earthlink.net ~ www.nevadaosteopathic.org

Last Name First Name Middle Initial

DOB: _____ State License# _____ AOA# _____

Please supply both home and office address. Check preferred mailing site.

Office address _____
street city state zip

Home address _____
street city state zip

I would like to be included in the NOMA referral base, listed on both website and directory.

Office phone _____ Home Phone _____

Fax number _____ EMAIL _____

If married please provide your spouse's name: _____

Specialty _____ OMT: YES NO

Board Certified: YES NO **Current Practice Status:** Full Time Part Time Retired
 Resident Faculty Intern

I would be interested in:

mentoring being a preceptor allowing a student to shadow accepting undergraduates

Are you interested in serving on a NOMA committee? Yes No (please circle one)

Osteopathic College: _____ Graduation Year: _____

Membership Dues
Dues year is July 1 through June 30

Physician Practicing in Nevada.....	\$400.00
Resident.....	\$ 20.00
Intern.....	\$ 20.00
Physician in first year of practice after Residency.....	\$ 75.00
Second Year of Practice after Residency.....	\$150.00
Third Year of Practice after Residency.....	\$285.00
Associate Member—Licensed in Nevada, Practicing Solely outside of Nevada.....	\$ 50.00
Retired Physician.....	\$ 50.00
Friend of the Profession.....	\$250.00

Dues with an application received after January 1 will be pro-rated: call our office for verification of amount.

Please mail completed application to:

Nevada Osteopathic Medical Association PO Box 90601 Henderson, NV 89009-0601

Or email completed application to: nvoma@earthlink.net

NOMA will accept a check, Visa or MasterCard.

Card Number Expiration Date Security Number

I hereby agree if elected to membership in the NEVADA OSTEOPATHIC MEDICAL ASSOCIATION, I will uphold and abide by said Association's Constitution and Bylaws. I certify that my practice conforms with and I hereby subscribe to the Code of Ethics of the American Osteopathic Association. I also certify that my license to practice is in good standing. All information by me in this application, is true to my best knowledge and belief.

Date

Signature