NEVADA OSTEOPATHIC MEDICAL ASSOCIATION
MEMBERSHIP APPLICATION

403 Max Court ~ Henderson, NV 89011
(702) 434-7112 ~ Fax (775) 787-6430
nvoma@live.com ~ 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

☐ Do not include me in the NOMA referral base.

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
Military	$ 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.
Completed application to: Nevada Osteopathic Medical Association 403 Max Court Henderson, NV 89011
Or email completed application to: nvoma@live.com

NOMA will accept a check, Visa, MasterCard. American Express or Discovery.
Online payment at www.regonline.com/nomarenewal2016

_____
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

Information provided is confidential and not sold.