

MEMBERSHIP APPLICATION

NEVADA OSTEOPATHIC MEDICAL ASSOCIATION
P.O. Box 90601~ Henderson, Nevada 89009-0601
(702) 434-7112 ~ Fax (702) 434-7110
nvoma@earthlink.net ~ www.nevadaosteopathic.org

PLEASE TYPE OR PRINT

Name: Last First Middle Initial

Date of Birth State License # AOA #

Check preferred mailing site but supply home and office address – Home information is confidential

Office _____

Home _____

Office phone _____ Home Phone _____

Fax number _____ EMAILrequired _____

If married please provide your spouses name: _____

Specialty _____

Board Certified _____ By _____ OMT Yes No

Current Practice Status: Active Practice Part Time Faculty Resident Intern Retired

I would be interested in: NOMA Committee: circle choice Technology Gov Affairs CME Membership
 mentoring preceptorship allowing a student to shadow accepting undergraduates

Pre-Osteopathic College Degree Year

Osteopathic College Graduation Year

IF YOU ANSWER “YES” TO ANY OF THE FOLLOWING QUESTIONS, PLEASE GIVE FULL DETAILS (USE SEPARATE SHEET OF PAPER, IF NEEDED)

- A. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily limited, suspended or revoked? Yes No
- B. Have any complaints been filed against you with reference to your practice? Yes No
- C. Have your privileges at any hospital ever been revoked or involuntarily suspended, diminished, revoked or not renewed? Yes No
- D. Have you been convicted of a felony? Yes No

Details: (please use additional sheet of paper if necessary): _____

List all of current and previous state associations and/or professional organizations

Name and Locations of Organization	Status	Appt. Dates

D.O. references: (If possible list at least one NOMA Member)

Name	Address

Membership Dues -- Dues year is July 1 through June 30

Physician Practicing in Nevada.....	\$400.00
Resident.....	\$ 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
Intern.....	\$ 20.00
Retired Physician.....	\$ 50.00

Dues with an application received after January 1 will be pro-rated: call for verification of amount. Mail application and check made out to "NOMA" or complete credit card info below.

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NOMA will bill your Visa or Mastercard only. Please complete the following:

 Name as shown on card (please print or type)

 Card Number Expiration Date
 Security code: _____ Billing zip code: _____

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. All information completed by me in this application is true and accurate, to my best knowledge and belief.

 Signature Date