



**AMERICAN OSTEOPATHIC COLLEGE OF PATHOLOGISTS, INC.**

**MEMBERSHIP APPLICATION**

(Please Print Legibly)

**Name** \_\_\_\_\_ **Title**  DO  MD  Other \_\_\_\_\_

**Gender:**  Male  Female \_\_\_\_\_ **Marital Status**  Married  Single \_\_\_\_\_

**Contact Preference**  Work  Home \_\_\_\_\_

**HOME CONTACT INFORMATION:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

**WORK CONTACT INFORMATION:**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

Please mark which address you would like in the AOCPP published directory.  Home  Work

**Active Military?**  Yes  No \_\_\_\_\_ Rank \_\_\_\_\_ Until \_\_\_\_\_

Hospital or Clinic Affiliations: \_\_\_\_\_

Type of Practice ( ex. AP, CP, etc.) \_\_\_\_\_

AOA Member:  Yes  No \_\_\_\_\_ AOA Member # \_\_\_\_\_

State Licensed: \_\_\_\_\_ License Date: \_\_\_\_\_ Number: \_\_\_\_\_

**TRAINING BACKGROUND INFORMATION**

Premedical Training: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Medical Training: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Internship Training: \_\_\_\_\_ Graduation Year: \_\_\_\_\_

Residency Training: \_\_\_\_\_ Date(s): \_\_\_\_\_

ABP(MD) Certification  Yes  No \_\_\_\_\_ Types(ex.AP.CP.,etc) \_\_\_\_\_ Date(s): \_\_\_\_\_

Board Certification (most recent): \_\_\_\_\_ Original Certification Date: \_\_\_\_\_  Not Taken

If accepted for membership I agree to abide by the Code of Ethics and the Constitution and Bylaws of AOCPP. By submission of this document, I authorize the release of the information contained herein and in membership files of those organizations and hospitals whom I may subsequently apply for membership; and the release to AOCPP by organizations and hospitals of information relative to my previous membership in those organizations. I am an osteopathic medical student, a resident, or a licensed physician in compliance with the state board and medical licensure and/or discipline's order.

**Membership Category:**

Active (\$300)  1<sup>st</sup> year in practice (\$150)  Retired (\$100)  Candidate-Resident(\$10)  Student (free)

Check enclosed for \$ \_\_\_\_\_

Were you referred by an AOCPP member?  Yes  No If yes, please list \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please mail to:**

American Osteopathic College of Pathologists, Inc  
142 E. Ontario St.  
Chicago, IL 60611

Phone- 312-202-8197  
Fax- 312-202-8224