

American Academy of Pediatric Osteopathy

Membership Application

Name: _____ Date: _____

AAO# _____

I am a(n): Attending DO MD DDS International DO Resident PGY_____

Student MS_____

Specialty: Peds FM ONMM Other_____ # Years in practice_____

Board Certifications (Circle All that apply): Peds FM ONMM Other:_____

Medical School: _____ Graduation Year: _____

I am willing to have the following rotators: MS3 MS4 Undergrad fellow Residents N/A

I am willing to lecture to: MS1 MS2 MS3 MS4 Residents Attendings N/A

Office Name and Address: _____

Website: _____

Email: _____

Phone: _____

May we publish above contact and specialty info on the website? Yes No

Preferred Correspondence Address: Same as above _____

Email: _____

Phone: _____

Membership Fees:

Student: \$40 (One time fee)

Resident: \$60 (One time fee)

Physician: \$100 a year

International: \$120 a year

Make Checks Payable to American Academy of Pediatric Osteopathy

Signature: _____

I certify that the above information is true and correct and agree to abide by the Constitution and Bylaws of the American Academy of Pediatric Osteopathy. I hereby, authorize the American Academy of Pediatric Osteopathy to charge me the amount of selected membership.