Maine Chapter
**acofp**

Maine Chapter of the
American College of
Osteopathic Family Physicians

# MEMBERSHIP APPLICATION

Full Name: ______________________________________________________________

Mailing Address: _________________________________________________________

City: __________________________________ State: ___________ Zip: _____________

Phone: ________________ Fax: ________________ Email address: __________________

Date of Birth: ______________________________

On what percentage of your patients do you use OMT? ___________________

Are you certified by the American Osteopathic Board of Family Physicians? ___Yes ___No

Check categories applicable to 25% or more of your patients:

___ Obstetrics ___ Pediatrics ___ Adolescent ___ Geriatric ___ General/Other

American Osteopathic Association (AOA) #: _____________________

Maine Osteopathic Association (MOA) #: ________________________

Medical College: __________________________________ Graduation Year: ____________

Internship Program: ________________________________ Graduation Year: ___________

**Annual Membership Fees:**

| | | |
|---|---|---|
| ______ | ***Active Physician*** | ***$50.00*** |
| ______ | ***Residents/Interns*** | ***$25.00*** |
| ______ | ***Students*** | ***$0*** |

**Payment Method:** ___ Check enclosed (*payable to:* ***MEACOFP***)
Credit Card: ____ VISA ____ Mastercard ____ American Express
Card #: ______________________________________ Exp date: ______________________
Card holder: __________________________________ ID # (last 3 digits on back of card): _________

Mail completed application and payment to:

***Maine Chapter ACOFP***
***693 Western Avenue, #1***
***Manchester, ME 04351***
*Fax: 207-623-4228 (credit card payments only)*

*"Excellence In Medicine – Healing Though Caring"*