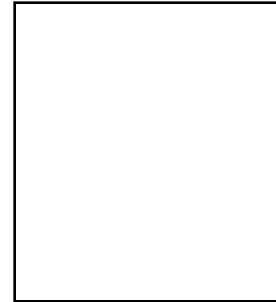


**Dayton District (III) Academy of Osteopathic Medicine
320 W. Grand Ave - Dayton, OH 45405 937-723-3438**



Name: _____
Last First M.I.

(Please attach a recent picture)

Sex _____ **Birthplace** _____ **Date of Birth** _____

Specialty: _____ **AOA Number:** _____

Office Address _____ **Home Address** _____

Office Telephone _____ **Home Telephone** _____

Office Fax _____ **Spouse Name** _____

Pager # _____ **UPIN #** _____

Mail delivered to: **Home** **Office** or
 E-mail _____
(check one)

MEDICAL LICENSE:

State/Province	Certificate Number	Expires
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MEDICAL EDUCATION & TRAINING:

Medical School	Completion	Dates
----------------	------------	-------

Internship	“	“
------------	---	---

Residency	“	“
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Postgraduate	“	“
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Fellowship	“	“
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Board Certification:

Specialty	Date of Certification
-----------	-----------------------

_____	“ “
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_____	“ “
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Current Specialty Society Memberships

Current Hospital Appointments

Current Teaching Appointments

Please check the appropriate box and initial as indicated for each question or statement.

1) Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended or revoked? Yes No

2) I hereby certify that I am a legally licensed physician residing or practicing in the twelve counties in the District (III) Academy of Osteopathic Medicine in the State of Ohio and that I have not been convicted of a felony. If accepted as a member, I agree to abide by the Constitution and Bylaws of my district academy and the Ohio Osteopathic Association, and the Principles of Medical Ethics of the American Osteopathic Association printed on the following page. ____ (initial)

3) I understand that conviction for fraud or a felony, or actions involving revocations, suspensions, limitation, probation, or any other sanctions or conditions imposed upon a license to practice medicine or disciplinary action by the Ohio Osteopathic Association or hospital staff, after due notice and hearing, may result in censure, suspension or expulsion of a member. The Health Care Quality Improvement Act requires professional societies to report certain professional review actions that adversely affect membership, including denial of membership to the National Practitioner Data Bank. ____ (initial)

4) I hereby release, and hold harmless from any liability or loss the Dayton District Academy of Osteopathic Medicine, the Ohio Osteopathic Association, and the American Osteopathic Association, their officers, agents, employees and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications and hereby release from any liability any all individuals and organizations, who, in good faith and without malice provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership. ____ (initial)

Signature _____ Date _____

Date approved ____ / ____ / ____

DDAOM Officer Signature: _____

Recruiting member name: _____