



The Ohio Orthopaedic Society
66 East Lynn Street - Columbus, Ohio 43215
Telephone (614) 464-2878 ♦ Fax (614) 464-2694
Website: www.OhioOrthoSociety.org

Application for Membership

As a practicing physician residing and/or practicing within the State of Ohio, and whose chief interest is confined to the practice of orthopaedics, I hereby make application for membership in the Ohio Orthopaedic Society, and submit the following information in support of my request for affiliation.

PLEASE COMPLETE ALL BLANKS (Print or Type)

CONTACT INFORMATION

Full Name: _____ (M.D. or D.O.)
(First) (Middle) (Last) (Circle one)

Date of Birth: ____/____/____ Email: _____

Specialty: _____ Years at location: _____

Practice Name: _____

Office Address: _____

City _____ State _____ Zip _____ County _____

Office Phone (____) _____ - _____ FAX (____) _____ - _____

Office Web Site Address: _____

EDUCATION

Pre-Medical Education

School (s) _____ Year Graduated _____

Medical Education

School(s) _____ Year Graduated _____

Current Hospital Affiliations: _____

CERTIFICATION

Are you certified by American Board of Orthopaedic Surgery?

Yes _____ Please list year of certification: _____

No _____ Are you board eligible? _____

Are you certified by American Osteopathic Board of Orthopaedic Surgery?

Yes _____ Please list year of certification: _____

No _____ Are you board eligible? _____

Signature of Applicant _____ Date: _____

Yearly dues in the Ohio Orthopaedic Society are \$275.00. Do not send dues with this application. You will be billed upon acceptance into the Society. You may Fax this form to (614) 464-2694 or mail it to the Society office.

Questions?? Contact Steve Landerman, Executive Director, at (614)464-2878 or email - Steve@OhioOrthoSociety.org