



The Ohio Orthopaedic Society

66 East Lynn Street • Columbus, OH 43215

Tele. 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

Office Address: _____

City _____ Zip _____ County _____

Office Telephone Number (____) _____ - _____ Fax (____) _____ - _____

E-mail: _____

Home Address: _____

City _____ Zip _____ County _____

Home Telephone Number (____) _____ Date of Birth: ____ / ____ / ____

Spouse Name (Optional) _____

EDUCATION

Pre-Medical Education

School(s) _____

Degree _____ Year Graduated _____

Medical Education

School(s) _____

Year Graduated _____

Internship

Place(s) Interned _____

Dates _____

Post-Graduate Work; Fellowship; Orthopaedic Residencies, Etc.

Workplace(s) _____

Dates _____

MISCELLANEOUS INFORMATION

Are you certified by the American Board of Orthopaedic Surgery?

_____ Yes Please list year of certification: _____

_____ No Are you board eligible? _____

Are you certified by the American Osteopathic Board of Orthopaedic Surgery?

_____ Yes Please list year of certification: _____

_____ No Are you board eligible? _____

I have been practicing at my current location for _____ years.

Local Hospital Staffs: _____

Institutional Connections: _____

Signature
Of Applicant: _____ Date: _____