

**The Ohio Orthopaedic Society**

66 East Lynn Street

Columbus, OH 43215

PH (614) 537-3319 Fax (614) 363-2647

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)**

**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 (\_\_\_\_\_) \_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_**

**EDUCATION**

**Medical Education**

School(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year Graduated \_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**10% of yearly dues are used for political activity in Ohio and Washington, D.C.**

**PAYMENT INFORMATION**

**Yearly dues for the Ohio Orthopaedic Society are $375.00.**

Make checks payable to **The Ohio Orthopaedic Society** and return this form to:

66 East Lynn Street, Columbus, Ohio 43215 Fax (614) 363-2647

**Credit Card**

I hereby authorize the following amount to be charged to my credit card. Visa \_\_\_\_\_ Master Card \_\_\_\_\_ Discover \_\_\_\_\_ AMX \_\_\_\_\_\_

Amount Authorized: \_\_\_\_\_\_\_\_\_\_\_\_ Card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date: \_\_\_\_\_\_\_ Name as it appears on card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address of Credit Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Questions? Contact Steve Landerman, Executive Director, email—steve@ohioorthosociety.org