

AODME

Association of Osteopathic Directors and Medical Educators

COLLEGIUM OF FELLOWS

PHYSICIAN APPLICATION

NAME: _____
Last First Middle Initial Date of Birth

ADDRESS: _____
Hospital/Educational Institution

Street City State Zip

Telephone: _____ **Fax:** _____ **Email:** _____

TITLE: _____ **Date Started:** _____

EDUCATION:

College/University Degree Graduation Date

Osteopathic Education Degree Graduation

INTERNSHIP:

Hospital Type Dates

RESIDENCY:

Hospital Specialty Dates

Board Eligible: Yes _____ **Board Certified:** Yes _____ **Certification #** _____
No _____ No _____

In which area: _____

Hospital Specialty Dates

Please attach additional page if required.

POSTGRADUATE TRAINING AND DATES:

Fellowship(s): _____

Assistantship(s): _____

Teaching Appointment(s): _____
Other Hospital Affiliation (Dates & Current Status): _____

LICENSURE(S):

State: _____ License No: _____ Effective to: _____
State: _____ License No: _____ Effective to: _____

MEMBERSHIP(S):

Local Society: _____ Expiration Date: _____
State Society: _____ Expiration Date: _____
National Society: _____ Expiration Date: _____
Other (List Effective Dates): _____

AOA MEMBERSHIP NUMBER:

Applicant's Signature: _____ Date: _____

SPONSORSHIP:

Please list the name and address of your sponsor from the Collegium.

I have reviewed this application and documentation and feel that it is complete.*

Sponsor's Signature: _____ Date: _____

***PLEASE REMEMBER TO INCLUDE YOUR \$100 APPLICATION FEE, C.V.,
AND OTHER DOCUMENTATION OF YOUR ACTIVITIES***

* Per Par. 5.3, Regulations Governing Fellowship, please attach a letter of support from the Collegium Fellow Sponsor.