ADVOCATES FOR THE AMERICAN OSTEOPATHIC ASSOCIATION

MEMBERSHIP TYPE:

____Regular Member	$50.00	$_____
____Widow, Retired	$10.00	$_____
____Student, Intern, Resident	$ 5.00	$_____
TOTAL AMOUNT OF PURCHASE		**$_____**

Name (please print)_____

Phone_____ Fax _____

Address_____ City_____ State____ Zip _____

Email_____

Physician Name (optional)_____

☐ **YES!** Please contact me about serving on the Board or a committee

PAYMENT OPTIONS:

(1) Cash
(2) Check –please make check payable to AAOA / Check#_____
(3) Credit Card

Charge Amount $_____ (check one) ☐ Visa ☐ MasterCard

Card #_____ Exp. Date_____

Name on Card_____

Signature_____

Please return this form with payment to:

AAOA
142 E. Ontario St., 4th Fl.
Chicago, IL 60611
Fax: 312-202-8224
Email: aaoa@osteopathic.org