FSACOFP MEMBERSHIP APPLICATION

APPLICANT INFORMATION		
Physician Name:		
Date of birth:	AOA #	Florida License #
Phone:	Email:	
Current Home Address:		
City:	State:	ZIP Code:

PRACTICE CONTACT INFORMATION		
Current employer:		
Employer address:		
Office/Cell Phone:	E-mail:	Fax:
City:	State:	ZIP Code:

OSTEOPATHIC TRAINING	
Osteopathic College:	
Graduation Year:	
Residency Program:	Completion Date:

SPECIALTY /CERTIFICATION
Specialty:
Certifications:

SIGNATURES	
By my signature, I hereby agree to practice, comply, and govern my conduct in accordance with the code of ethics of the FSACOFP and such other standards of conduct and practice ethics adopted by the Association and make application for membership in the FSACOFP. Membership dues are not tax deductible as charitable contributions, but may be deductible as ordinary and necessary business expenses subject to restrictions imposed as a result of association lobbying activities.	
Signature of applicant:	Date:

Please check the applicable membership category below:

☐ Active Physician - $150 ☐ Residents, Interns, and Students - No Fee

☐ Advocate Member - $25 Advocate Name: _____

Mail or fax completed application with payment to:

FSACOFP – The Hull Building
2007 Apalachee Parkway, Suite A, Tallahassee, FL 32301
Phone (888) 907-6851 / Fax (850) 942-7538