

**APPLICATION FOR RECERTIFICATION  
EXAMINATION IN  
NEUROMUSCULOSKELETAL MEDICINE**

AOA # \_\_\_\_\_

DATE: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Middle

\_\_\_\_\_  
Home Address City State Zip

\_\_\_\_\_  
(Area Code) Home Telephone No. Email (Personal/Home)

\_\_\_\_\_  
Office Address City State Zip

\_\_\_\_\_  
(Area Code) Office Telephone No. (Area Code) Office Fax No.

\_\_\_\_\_  
Social Sec. Number E-mail address (work/business)

Mailing Contact/Address Info  
Prefer Home/Personal \_\_\_\_\_ or Prefer Work/Office \_\_\_\_\_

**ORIGINAL CERTIFICATION:**

AOBSPOMM/AOBNMM Certificate NO. \_\_\_\_\_ Date of Certification \_\_\_\_\_

Qualified for AOBSPOMM Examination by Completion of Practice Years: \_\_\_\_\_

or Residency Program \_\_\_\_\_

\_\_\_\_\_  
Residency Location City, State Year of Completion

Certified in other specialties? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, list specialties:

\_\_\_\_\_  
Specialty Date Certified: \_\_\_\_\_

\_\_\_\_\_  
Specialty Date Certified: \_\_\_\_\_

**EDUCATION:**

\_\_\_\_\_  
Name of Osteopathic Institution City, State Year of Graduation

**RETURN ALL APPLICATION MATERIALS TO:**

Attn: AOBNMM Coordinator

Please insert  
your photo here

RECERTIFICATION  
3500 DePauw Boulevard, Suite 1080  
Indianapolis, IN 46268

(head and shoulders pose)

**Remember to attach a copy of your AOA CME printout for the current 36 months**

LICENSURE: (Please forward copy of current license to practice)

_____	_____	_____	_____
State	License No.	Date Issued	Date Expires
_____	_____	_____	_____
State	License No.	Date Issued	Date Expires

PROFESSIONAL MEMBERSHIPS:

_____	_____
_____	_____
_____	_____

BASIC ELIGIBILITY REQUIREMENTS:

- 1) Certification by the AOBSPOMM or AOBNMM
- 2) Current practice of osteopathic manipulative medicine (specialized or integrated practice of any other AOA certifying board discipline)
- 3) Membership in the American Osteopathic Association
- 4) Compliance with the AOA's CME requirements (provide individual Activity Report)
- 5) Full, unrestricted, current medical license in the state where practice is conducted

EXAMINATION AND PROCESSING FEES:

- \$500.00 Examination fee (*payable at the time of application*)
- \$ 75.00 *Non-refundable fee withheld from examination fee for application processing when applicant is ineligible or requests a refund*
- \$100.00 *\*Re-scheduling fee*

\*Candidate will have one retake option at no charge. Additional retakes will be assessed at \$100.00 each.

Payment must accompany the application. Please indicate method of payment below:

_____	_____	\$ _____
Check Number	Date of Check	Amount Paid
_____	_____	\$ _____
Credit Card Number	Expiration Date	Amount Paid

AOBNMM Recertification Application

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Please answer each of the following questions. If the answer is yes to any, please give detailed explanation in comments area.

YES    NO

Has your license to practice, in any jurisdiction, ever been revoked, restricted or suspended? \_\_\_\_\_

Have you been the subject of any disciplinary action by any medical society or staff within the past 5 years? \_\_\_\_\_

Has a hospital appointment been terminated or restricted or have you resigned after being notified you would be terminated or restricted within the past five years? \_\_\_\_\_

Have you ever been convicted of a crime other than a minor traffic violation? \_\_\_\_\_

Within the past 5 years, have you been involved in a proceeding in which professional malpractice on your part was alleged? \_\_\_\_\_

Have you been subject to disciplinary action for substance abuse? \_\_\_\_\_

COMMENTS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPLICATION STATEMENT:

I hereby make application to the AOBNMM for admission to the recertification examination in Neuromusculoskeletal Medicine.

I agree that my professional qualification, including my moral and ethical standing in the medical profession and my competence in clinical skills, will be evaluated by the Board and that the Board may make inquiry of institutions named in this application as the Board may deem appropriate with respect to such matters; and I agree that the sources and all information furnished to the Board in connection with its inquiry shall be confidential and not subject to disclosure, through legal process or otherwise, to me or to any one acting on my behalf. I agree that the AOBNMM and the AOA shall be the sole judge of my credentials and qualifications for admission to the examination and for recertification.

I hereby declare under penalty of perjury that the information given in this application is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date