

APPLICATION  
AMERICAN OSTEOPATHIC BOARD  
OF NEUROMUSCULOSKELETAL MEDICINE  
(Please Print Legibly or Type)

NAME: \_\_\_\_\_  
(Last) (First) (Middle)

OFFICE ADDRESS: \_\_\_\_\_  
( ) check if preferred (Street)  
Telephone: \_\_\_\_\_  
( C i t y ) ( S t a t e ) Z i p )  
FAX: \_\_\_\_\_  
Email: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
( ) check if preferred (Street)  
Telephone: ( ) \_\_\_\_\_  
(City) (State) (Zip) FAX: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_

GRADUATE OF: \_\_\_\_\_ YEAR: \_\_\_\_\_  
(Osteopathic College)

INTERNSHIP: \_\_\_\_\_ DATES: \_\_\_\_\_  
(Hospital, Medical Center, etc.) (Mo/Day/Yr)-(Mo/Day/Yr)  
\_\_\_\_\_  
(City, State)

RESIDENCY: \_\_\_\_\_ DATES: \_\_\_\_\_  
(Hospital, Medical Center, etc.) (Mo/Day/Yr)-(Mo/Day/Yr)  
\_\_\_\_\_  
(City, State) TYPE: \_\_\_\_\_

RESIDENCY DIRECTOR: \_\_\_\_\_

PLUS-ONE RESIDENCY: \_\_\_\_\_ DATES: \_\_\_\_\_  
(Hospital, Medical Center, etc.) (Mo/Day/Yr)-(Mo/Day/Yr)  
\_\_\_\_\_  
(City, State)

RESIDENCY DIRECTOR: \_\_\_\_\_

OMM/OPP PRE-DOCTORAL FELLOWSHIP: \_\_\_\_\_ Yes DATES: \_\_\_\_\_  
(Mo/Day/Yr)-(Mo/Day/Yr)

LOCATION: \_\_\_\_\_

ARE YOU NOW IN ACTIVE PRACTICE? \_No \_\_\_\_\_ Yes YEARS IN PRACTICE: \_\_\_\_\_

AOA #: \_\_\_\_\_ NUMBER OF YEARS MEMBER OF AMERICAN OSTEOPATHIC ASSOCIATION: \_\_\_\_\_

OTHER CERTIFICATIONS: \_\_\_\_\_

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
PLEASE  
AFFIX  
RECENT  
PHOTOGRAPH  
HERE  
(Head & Shoulders pose)

See "Information for Applicants" brochure for Prerequisites and Requirements for certification.

Send completed application, with a copy of all documentation materials, and fees, to:

AOBNMM

3500 DePauw Boulevard, Suite 1080

Indianapolis, Indiana 46268

Telephone: (317) 879-1881 Fax: (317) 879-0563

Application deadlines: July 1 and December 1

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
(city/state)

a) Please list all formal education and training from high school to present.\*

School	Location	Dates From/To
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b) Please list practice locations since receiving D.O. degree.

Practice Locations	Dates From/To
_____	_____
_____	_____
_____	_____

c) Have you had any malpractice actions brought against you or are there any pending?

\_\_\_\_\_yes \_\_\_\_\_no (If yes, please explain.)\* \_\_\_\_\_  
\_\_\_\_\_

d) Have you in the past or do you currently hold a federal or state controlled substance registration?

\_\_\_\_\_yes \_\_\_\_\_no If yes, has this registration even been limited or revoked?  
\_\_\_\_\_yes \_\_\_\_\_no (If yes, please explain.)\* \_\_\_\_\_  
\_\_\_\_\_

e) Have you ever held privileges on a hospital staff? \_\_\_\_\_yes \_\_\_\_\_no

If yes, have any privileges been revoked or limited? \_\_\_\_\_yes \_\_\_\_\_no  
( If yes, please explain.)\* \_\_\_\_\_  
\_\_\_\_\_

f) In what States do you hold an unrestricted medical license?  
\_\_\_\_\_

g) Have you ever had your license to practice medicine revoked or limited? \_\_\_\_\_yes \_\_\_\_\_no

( I f y e s , p l e a s e e x p l a i n . ) \* \_\_\_\_\_

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**[PLEASE REMEMBER TO INCLUDE A COPY OF YOUR CURRENT LICENSE TO PRACTICE.]**

\*Use space below and/or separate sheet, if necessary.

Application deadlines: July 1 and December 1

REVISED 7/7/99 - Last revised 5/13/09