

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

NAME: _____
(Last) (First) (Middle)

OFFICE ADDRESS: _____
() check if preferred (Street)

(City) (State) Zip Telephone: _____

FAX: _____ Email: _____

HOME ADDRESS: _____
() check if preferred (Street)

(City) (State) (Zip) Telephone: ()

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: _____

PLEASE

(Signature)

(Date)

AFFIX RECENT
PHOTOGRAPH HERE
(Head & Shoulders pose)

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If yes, have any privileges been revoked or limited?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
(If yes, please explain.)* _____

[Please remember to include a copy of your current license to practice.]

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

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 deadline: August 1