



## The American Osteopathic Association of Prolotherapy Integrative Pain Management

Office: (302)530-2489 Fax: (302)376-8081 Prolotherapycollege.com

### Membership Application

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

Office Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Fax( ) \_\_\_\_\_

Home Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

City/ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Fax( ) \_\_\_\_\_

Email address \_\_\_\_\_ Office Name, Address/Phone # posted on Website? Y \_\_\_ N \_\_\_

**Please check which address should be used for the membership roster.**

Please accept my application for membership in the College

I am licensed and practice in the following states \_\_\_\_\_

I am a member in good standing in the following professional associations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I am \_\_\_\_\_ or I am **not** using prolotherapy/sclerotherapy \_\_\_\_\_

If so, please specify areas of use: Hernia ( ) Rectal Diseases ( ) Varicose Veins ( ) Hypermobility Joints ( )

Hydrocele ( ) Other \_\_\_\_\_

**The following documents must be included with your application**

A copy of current practice license must be attached.

A copy of your C.V.

A membership fee of \$200.00., Medical Student memberships are free

Please make checks payable to ACOPIPM, Inc. and mail to: AOAIPM, Inc.

Or pay by M/c \_\_\_ Visa \_\_\_ Amex \_\_\_ Discover \_\_\_ Other \_\_\_ 303 S. Ingram Ct.

CC# \_\_\_\_\_ Exp. \_\_\_\_\_ Middletown, DE 19709

CC# Billing Address Zip Code \_\_\_\_\_ CVV (# digits on back of CC) \_\_\_\_\_

I do hereby certify that the information provided on this application is true to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_