



The American Osteopathic Association of Prolotherapy Integrative Pain Management

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

Membership Application

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 () Hypermobile 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 _____