The American Osteopathic Association of Prolotherapy Regenerative Medicine

Office: (302)530-2489 Prolotherapycollege.com office@prolotherapycollege.org

Membership Application

Name _____ *AOA #* _____

___ *Office Address* _____*Phone ( )*_____

*City/State*_____ *Zip Code* _____ *Fax ( )*_____

Website _____
___ *Home Address* _____*Mobile ( )*_____

City/ State _____*Zip Code*_____ *Fax ( )*_____

Email address _____
Office Name, Address, Phone #, Website posted on AOAPRM 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/country*_____

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 AOAPRM, Inc. and mail to: AOAPRM, 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* _____