



The Ohio Orthopaedic Society
66 East Lynn Street - Columbus, Ohio 43215
Telephone (614) 537-3319 ♦ Fax (614) 464-2694
Website: www.OhioOrthoSociety.org

Application for Membership

As a practicing physician residing and/or practicing within the State of Ohio, and whose chief interest is confined to the practice of orthopaedics, I hereby make application for membership in the Ohio Orthopaedic Society, and submit the following information in support of my request for affiliation.

PLEASE COMPLETE ALL BLANKS (Print or Type)

Full Name: _____ (M.D. or D.O.)
(First) (Middle) (Last) (Circle one)

Date of Birth: ____/____/____ **Email:** _____

Specialty: _____ **Years at location:** _____

Practice Name: _____

Office Address: _____

City _____ **State** _____ **Zip** _____ **County** _____

Office Phone (____) _____ - _____ **FAX** (____) _____ - _____

EDUCATION

Pre-Medical Education

School (s) _____ Year Graduated _____

Medical Education

School(s) _____ Year Graduated _____

CERTIFICATION

Are you certified by American Board of Orthopaedic Surgery?

Yes _____ Please list year of certification: _____ No _____ Are you board eligible? _____

Are you certified by American Osteopathic Board of Orthopaedic Surgery?

Yes _____ Please list year of certification: _____ No _____ Are you board eligible? _____

Signature of Applicant _____ Date: _____

Yearly dues for the Ohio Orthopaedic Society are \$375.00.

Make checks payable to **The Ohio Orthopaedic Society** and return this form to:
66 East Lynn Street, Columbus, Ohio 43215 Fax (614) 464-2694

Credit Card

I hereby authorize the following amount to be charged to my credit card. Visa _____ Master Card _____ Discover _____ AMX _____

Amount Authorized: _____ Card # _____

Expiration Date: _____ Name as it appears on card: _____

Billing Address of Credit Card _____

Questions? Contact Steve Landerman, Executive Director, email-- steve@ohioorthosociety.org