HCOMS Membership Form

Name: _____ Date: _____

Home Address: _____

Home City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Personal email: _____

Specialty: _____ AOA/AMA Number: _____

Work Address: _____

Work City, State, Zip: _____

Work Phone: _____ Fax: _____

Website: _____

Work email: _____

Preferred Address for mailings: Home_____ Work _____

List in Online Directory?

Work address? Yes_____No_____

Work website? Yes_____No_____ Work fax? Yes_____No_____

Work phone? Yes_____No_____ Work email? Yes_____No_____

Membership Level (please circle each item):

- Annual Physician Dues: $225
- Associate Membership: $150
- Retiree $50
- Residents, Interns, and Medical Students (Free)
- Legislative Action Contribution (Optional $100)
- Kenneth E. Webster Osteopathic Student Scholarship Fund (Optional $100)
- Jamaica Clinic Project (Optional $100)

MAIL TO:
HCOMS
PO Box 13489
St. Petersburg, FL 33733