Application for Resident Membership
American College of Osteopathic Surgeons

123 North Henry Street, Alexandria, VA 22314-2903
(800) 888-1312
www.facos.org

Membership Requirements
Membership is available to physicians who have graduated from an AOA-accredited or LCME-accredited college of medicine and are currently participating in a surgical residency training program either approved by the AOA or accredited by ACGME

Please include the $185 annual dues payment with your application.

Check #		Amount	

Applications and dues payments must be received by March 15th of each calendar year to apply for the current membership year.

Name	First / Middle / Last / Nickname		
Mailing Address ❑ Home ❑ Work	Street Address		
	City / State / Zip		
Work Telephone		**Home Telephone**	
Mobile Telephone		**Fax Number**	

E-mail Address		**Social Security #**	– –
Gender	❑ Male ❑ Female	**Date of Birth**	

OSTEOPATHIC DEGREE ☑ **Osteopathic Medical School**

DATE GRADUATED

❑ ACOM	❑ KCUMBCOM	❑ MWUAZCOM	❑ PCOM	❑ ROWANSOM	❑ WCUCOM
❑ ATSUSOMA	❑ LECOM	❑ MWUCCOM	❑ PNWUCOM	❑ UNECOM	❑ WVSOM
❑ ATSUKCOM	❑ LMUDCOM	❑ NSUCOM	❑ RVUCOM	❑ UNTHSCTCOM	
❑ BCOM	❑ LUCOM	❑ NYITCOM	❑ TOUROCOM	❑ UPKYCOM	
❑ CUSOM	❑ MSUCOM	❑ OSUCOM	❑ TUCOM	❑ VCOM	
❑ DMUCOM	❑ MUCOM	❑ OUHCOM	❑ TUNCOM	❑ WESTERNUCOMP	

ALLOPATHIC DEGREE ☑ **Allopathic Medical School**

College	Date Graduated

INTERNSHIP

Institution			
Location		**Exact Dates**	

CURRENT RESIDENCY TRAINING - If you are currently in an ACGME-accredited training program, please attach copy of current training contract.

Institution			
Location		**Exact Dates**	
OGME / Year PGY		**Surgical Specialty**	

←OVER PLEASE →

The application shall be endorsed by the Program Director or by an ACOS Member.

This it to certify that I have reviewed the application of Dr. ______________________________
for Resident Membership in the American College of Osteopathic Surgeons and consider the applicant's qualifications worthy of the favorable consideration of the Membership Committee.

	SIGNATURE	PRINTED NAME	DATE
Program Director			
Endorsing Physician			

The ACOS member who introduced me to the ACOS and encouraged my application ____________________
(Please Print Name)

RELEASE AUTHORIZATION

In furtherance of my application for resident membership in the American College of Osteopathic Surgeons (ACOS), I request and authorize any hospital and/or medical staff where I now have, have had, or have applied for medical staff privileges, and any organization of which I am a member or to which I have applied for membership, and any person who may have information, records, or documents which are deemed necessary by the ACOS to evaluate my eligibility for membership to provide such information to representatives of the ACOS. I agree that communications of any nature made to the ACOS regarding my fitness for membership may be made in confidence and shall not be made available to me under any circumstances.

I release any hospital, medical staff, organization, or person, and the ACOS and its representatives from any liability for acts performed or communications, reports, recommendations, or disclosures made, requested, or received in good faith and without malice in connection with provision, collection, or evaluation of information or opinions bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, ethics, behavior, or any other matter, whether or not requested, in connection with my membership in the ACOS.

I certify that the statements made by me in this application are true to the best of my knowledge and belief; and that I shall give every possible aid to the ACOS in its investigation of my qualifications as a surgeon.

I declare that I have read the Code of Ethics of the American Osteopathic Association.

I pledge that, if I become a member in the ACOS, I shall continue to abide by and uphold the Bylaws of the ACOS and the Code of Ethics of the American Osteopathic Association as interpreted by the ACOS.

I further pledge that, if honored by membership in the ACOS, any violation of ethical conduct on my part relating to hospital procedures or surgical practice shall be deemed cause for suspension or revocation of my membership in the ACOS.

Signed	**Date**

Please call the ACOS at (800) 888-1312 to receive a copy of the ACOS Bylaws and/or the AOA Code of Ethics.

April 2017