



WASHINGTON STATE ORTHOPAEDIC ASSOCIATION

APPLICATION FOR MEMBERSHIP

CONTACT INFORMATION:

Name: _____ Title: _____

Practice/Group Name: _____

Practice Address: _____ City/State/Zip: _____

Phone: _____ E-Mail: _____

Hospital Affiliation: _____

Home Address: _____

Home Phone: _____ Email: _____

Preferred Address for WSOA Correspondence: Home Work

EDUCATION: (School Name/Location & Years Attended)

Premedical Education: _____

Medical School: _____

Residency: _____

Fellowship: _____

Date of Board Certification: _____ Board Eligible: Yes No

Professional Society Memberships:

Membership Dues: One-Year Membership (Includes 2009 Annual Meeting Fees, and Legal / Legislative Funding for 2009 Action Plan)

- Active: \$750.00 (Physician who devotes at least 90% of their practice to Orthopaedic medicine)**
- Retired: \$100.00 (Previously Active Member fully retired from active practice)**
- Resident: \$ 0.00 (Person occupying an Orthopaedic residency or fellowship program in Washington state)**
- Affiliate: \$125.00 (Physicians assistant who devotes at least 90% of their practice to Orthopaedic medicine)**

Enclosed is my check for payment Please charge my Visa, MasterCard, or American Express

Name on card: _____

Number: _____ Exp. Date: _____

Please return completed application along with payment to:

WSOA
2033 Sixth Avenue, Suite 1100
Seattle, WA 98121

Fax: (206) 441-5863
Email: ddw@wsma.org
Questions? (206) 441-9762