The American Osteopathic Association of Prolotherapy Regenerative Medicine
Office: (302)530-2489 Prolotherapycollege.com office@prolotherapycollege.org

Membership Application

Name _____

AOA # (D.O. Physicians only) _____

Office Address _____ *Phone ( )* _____

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

Website _____

Email address _____
Office Name, Address, Phone #, Website posted on AOAPRM Website? Y____N____

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* _____

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

Email to: office@prolotherapycollege.org or apply online @ www.prolotherapycollege.org

CC# _____ *Exp. Date* _____
CC# Billing Address Zip Code _____ *CVV #* _____

I do hereby certify that the information provided on this application is true to the best of my knowledge.

Signature _____ *Date* _____