



American College of Osteopathic Obstetricians and Gynecologists

Medical Disability Dues Waiver

► Please type or print legibly

Name _____ AOA Number _____

Home Address _____

City _____ State _____ Zip Code _____

E-mail address _____ (Please check one) Male Female

Home Number (_____) _____ Fax Number (_____) _____

Pager Number (_____) _____ Other Number (_____) _____

MEMBER STATUS: REGULAR MEMBER SENIOR MEMBER

DATE DISABILITY OCCURRED: _____

OUT OF PRACTICE SINCE: _____

DO YOU EXPECT TO RETURN TO WORK? _____

IF YES, WHEN DO YOU ANTICIPATE RETURN? _____

ARE YOU ENGAGED IN OTHER TYPE OF PROFESSIONAL EMPLOYMENT? YES NO

IF YES, EXPLAIN: _____

Submit the following forms with the disability application:

- 1) Documentation of disability (Letter from your physician).
- 2) Income Tax Return (Evidence of income and liabilities since incurring your disability).
- 3) Please provide a more detailed description of your situation.

All such information is considered confidential and is only reviewed by the committee and select staff responsible for the preparation of such documents.

Please mail or fax to:
American College of Osteopathic Obstetricians and Gynecologists
8851 Camp Bowie West, Suite 120, Fort Worth, Texas 76116
(817) 377-0421 (800) 675-6360 (817) 377-0439 Fax