



SAN DIEGO ORTHOPAEDIC SOCIETY / WOA S.D. CHAPTER
MEMBERSHIP APPLICATION

Personal Information

Name _____
Address _____
City _____ State ____ Zip _____
Phone _____ Fax _____

Education

Medical School _____
Date of Graduation _____ License # _____
State _____ Exp. Date _____
Licensed as ____ MD ____ DO

Sponsor *(must be current voting WOA member)*

Name _____
Address _____
City _____ State ____ Zip _____
Office Phone _____ Fax _____

Please List Professional Affiliations

- I have submitted or am in the process of submitting an application to the central office of the Western Orthopaedic Association.
- I have been made aware of the benefits of membership in the central Western Orthopaedic Association however, at this time I have requested membership privileges in the local San Diego Chapter only.

Name (please print) _____
Signature _____ Date _____

Please mail completed membership application to the following address:

Lisa Vaughn, Executive Director
Western Orthopaedic Association San Diego Chapter
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(858) 278-8300 • Fax (858) 569-1337

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UCSD Resident Representative
Mathew Kinney, M.D.