San Diego Orthopaedic Society

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
3750 Convoy Street, Suite 201 • San Diego CA 92111
(858) 278-8300 • Fax (858) 569-1337