APPO Foundation
Association of Philippine-American Physicians of Ohio

APPLICATION AND RENEWAL FORM

(Please print or type)

NAME _____ _____ **SPOUSE**_____
Last name *First name* *Middle initial* *Formal designation (MD, DO, etc)*

ADDRESS

Office_____
Street *City* *State* *Zip*

Home _____
Street *City* *State* *Zip*

TELEPHONE NUMBERS:

Cell:_____ **Work** _____

Home _____ ****email:** _____

*****email strongly recommended***

Send mail to: □ **Office address** □ **Home Address**

EDUCATION

School of medicine _____Degree _____Yr of Graduation _____

City and Country _____

Internship _____

Residencies and Fellowship _____

_____

Hospital Affiliation_____

Practice status ☐ active ☐ retired ☐other

LICENSURE AND BOARDS

Licensed in _____ License # _____expiration date _____

Type of practice _____Years in practice _____

Please submit a curriculum vitae if applicable, listing of professional societes, positions currently held, scientific exhibits, lectures, books, scientific publications, honors and awards.

PERSONAL INFORMATION

Birthplace_____Country _____Citizenship _____

Sex : ( ) Male ( ) Female Marital status: _____Date of Birth _____

If elected, I will abide by the APPO Foundation Constitution and By Laws: _____
Signature

Annual Fee (regular) : $50.00
Lifetime : $250.00
APPO TAX ID #34-1343976