

### CONTACT INFORMATION

Designation(s):  DO  MD  PhD  Other \_\_\_\_\_

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

AOA# \_\_\_\_\_

Is this your first OMED? Yes  No

Update information in the AOA Member Record? Yes  No

Would you like this information shared with your Specialty College(s)? Yes  No

Would you like this information shared with your Alumni Organization? Yes  No

### OMED INFORMATION

Your primary specialty(ies) \_\_\_\_\_

Your specialty college membership numbers \_\_\_\_\_

Type of practice:

<input type="checkbox"/> Administration	<input type="checkbox"/> Direct Patient Care
<input type="checkbox"/> Consultant	<input type="checkbox"/> Inactive, Other
<input type="checkbox"/> Medical Education	<input type="checkbox"/> Intern, Resident, Fellow
<input type="checkbox"/> Medical Research	<input type="checkbox"/> Retired
<input type="checkbox"/> Other _____	

Type of employment:

<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Employed, Gov't/Military
<input type="checkbox"/> Employed, Hospital	<input type="checkbox"/> Medical School/University
<input type="checkbox"/> NonPatient Care	<input type="checkbox"/> Non Patient Care
<input type="checkbox"/> Solo Practice/Partnership	<input type="checkbox"/> Research
<input type="checkbox"/> Group Practice, Hospital-owned	
<input type="checkbox"/> Group Practice, Physician-owned	
<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____

### PARTICIPATING SPECIALTY GROUPS

- American Academy of **Osteopathy**
- American Osteopathic Academy of **Addiction Medicine**
- American Osteopathic College of **Allergy and Immunology**
- American College of Osteopathic **Family Physicians**
- American College of Osteopathic **Internists**
- American College of Osteopathic **Neurologists and Psychiatrists**
- American Osteopathic College of **Occupational & Preventive Medicine**
- American Osteopathic College of **Pathologists**
- American College of Osteopathic **Pediatricians**
- American Osteopathic College of **Physical Medicine and Rehabilitation**
- American Osteopathic Association of **Prolotherapy Regenerative Medicine**
- American Osteopathic Society of **Rheumatic Diseases**
- American Osteopathic Academy of **Sports Medicine**

### GUESTS AND CHILDREN


All guests attending any OMED events must be registered. **Your registration fee does not include events (Exhibit Hall, Block Party, Receptions) for your guests.** All guests and children MUST be registered and have a badge to attend any portion of OMED, including the Exhibit Hall and Receptions. Children 13 and under receive complimentary registration and may attend the Block Party and other receptions. Children, with an adult, must be registered in order to receive complimentary registration. Medical Students may not be registered as guests.


### GUEST / CHILD NAMES


1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### FOUR WAYS TO REGISTER

 **ONLINE**  
omed.osteopathic.org

 **PHONE**  
Toll Free (Domestic)  
(800) 424-5249

 **MAIL**  
AOA/OMED 2018  
Registration and Housing Office  
5202 President's Court, Ste. G100  
Frederick, MD 21703

 **FAX**  
(301) 694-5124

**Checks payable to:**  
**American Osteopathic Association**

### EMERGENCY CONTACT INFORMATION

Full Name \_\_\_\_\_

Phone \_\_\_\_\_

**CONTACT AOA:** Phone: (800) 621-1773 ext. 8256  
Email: [conventions@osteopathic.org](mailto:conventions@osteopathic.org)

## HOW TO SELECT THE APPROPRIATE REGISTRATION CATEGORY

Check **APPROPRIATE** categories on the registration form. The Specialty College Categories are for those who chose to register in a specialty category. Registrants may select up to four specialty categories. Please indicate your PRIMARY CHOICE and specialty college membership number. Your name will appear on the attendance roster of **each** practice organization selected and membership number that was provided. The other categories are for those who register **without** a practice designation.

Regardless of the registration category selected, registrants are entitled to attend **ANY** of the didactic sessions planned by **ANY** of the participating organizations. Membership in a participating affiliated organization is a requirement to register for a practice group, and AOA membership is a requirement for registration in ANY of the practice categories listed.

REGISTRATION CATEGORY	LATE/ON-SITE After August 22
<input type="checkbox"/> AOA Member (AOA)	945
<input type="checkbox"/> Specialty College (Must be AOA Member) (Designate up to 4 Specialties along with membership number(s) on the next page)	945
<input type="checkbox"/> AOA Non Member (NM)	1145
<input type="checkbox"/> Associate Member/Practice Manager (ASM)	300
<input type="checkbox"/> Non-DO (MD, PhD) (NDO)	1145
<input type="checkbox"/> One Day* Member (ODM) (Check one) <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue	325 575 525
<input type="checkbox"/> One Day* Non Member (ODN) (Check one) <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue	425 675 625
<input type="checkbox"/> Physicians Assistant (PA)	945
<input type="checkbox"/> Retired AOA Member (RET)	375
<input type="checkbox"/> Intern (I)	325
<input type="checkbox"/> Resident (R)	325
<input type="checkbox"/> Student (S)	100
<input type="checkbox"/> State Executive Director (OSED)	150
<input type="checkbox"/> Guest (GAOA)	150
<input type="checkbox"/> Advocates (ADV)	150
<input type="checkbox"/> Child 13 and under (CH)	0
<input type="checkbox"/> Military (MLT)	645

\* One Day attendees must indicate up to 1 attendance day. If multiple days are indicated, attendee will be automatically registered for full attendance.

## CME CREDITS

Some OMED session are dually accredited. Please indicate which type of CME credits you need:

- AOA Category 1A Credit  
 AMA PRA Category 1 Credit™  
 None

## DIETARY RESTRICTIONS

- Vegan  
 Vegetarian  
 Kosher  
 Gluten-Free  
 Allergies

Please specify \_\_\_\_\_

- Other \_\_\_\_\_

Please specify \_\_\_\_\_

## ASSISTANCE

Pursuant with the Americans with Disabilities Act, I require specific aids or service at the event location.

Please indicate type of need(s):

- Audio  Visual  Mobile

- Other \_\_\_\_\_

## CANCELLATIONS

A full refund, less a \$100 processing fee, will be issued if the cancellation request is received by Wednesday, August 22, 2018. Cancellation requests must be made in writing and may be sent to [AOAAttendee@Experient-Inc.com](mailto:AOAAttendee@Experient-Inc.com) or faxed to (888) 772-1888 by Wednesday, August 22, 2018. After August 22, 2018, cancellation requests will not be accepted and refunds will not be issued.

Credit Card (Check one)

- AMEX  DISCOVER  MASTERCARD  VISA

Credit Card No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

Name on Card \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_

PROMO CODE

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