

HAOPS Membership Application: 2023

PLEASE PROVIDE ALL APPLICABLE INFORMATION (*REQUIRED)

Board Action _____

DEMOGRAPHIC INFORMATION	
* Name:	_____
*Preferred Mailing Address:	_____
* Street Address:	_____
* City, State, Zip:	_____
* Phone:	_____
* E-Mail:	_____
AOA Number:	_____
Fax:	_____
Date of Birth:	_____
Hawaii License #:	_____

PRACTICE STATUS	
<input type="checkbox"/> Private Practice	<input type="checkbox"/> Resident/Fellowship
<input type="checkbox"/> Faculty or Hospital	<input type="checkbox"/> Internship
<input type="checkbox"/> *Medical School & Graduation Date: _____	<input type="checkbox"/> Government or Military
<input type="checkbox"/> *Internship & Year Completed: _____	<input type="checkbox"/> Other (detail): _____
<input type="checkbox"/> AOA Board Certified in: _____	<input type="checkbox"/> *Residency & Year Completed: _____
<input type="checkbox"/> *Area of Practice: _____	<input type="checkbox"/> ABMS Board Certified in: _____
Other Professional Degree(s): _____	

*Do you currently have an unrestricted license to practice medicine in the state listed in your address? Yes No

*Has your license ever been suspended or revoked? (If yes, please provide details separately.) Yes No

*Have you ever been convicted of a felony offense? (If yes, please provide details separately.) Yes No

By my signature, I authorize release of the information contained in this application and membership file to those organizations or hospitals to which I may subsequently apply for membership, and the release to HAOPS by organizations and hospitals of information relative to my membership in those organizations. I agree to practice, comply, and govern my conduct in accordance with the Code of Ethics of HAOPS and AOA and such other standards of conduct and practice ethics adopted by the Association.

Signature _____

Date _____

I AM APPLYING FOR:		
DO Member	<input type="checkbox"/> \$100.00	
Military	<input type="checkbox"/> \$100.00	
Associate (DO's residing out-of-state)	<input type="checkbox"/> \$100.00	
Friend of HAOPS	<input type="checkbox"/> \$100.00	
Academic (Student, Resident, or Intern)	<input type="checkbox"/> Free	\$0
HAOPS Donation	Optional	
TOTAL PAYMENT DUE \$		



Please make checks payable to **HAOPS** and send to:
Terri Kakugawa, DO
 91-1034 Nanahu Street
 Kapolei, HI 96707