OHIO OSTEOPATHIC ASSOCIATION
PETITION FOR REDUCED MEMBERSHIP DUES

The OOA Board of Trustees, upon verification by your local academy, grants dues reductions, for retirement, disability or financial hardship. In order to receive consideration, please complete section one **or** two below, and return this petition to the OOA Central Office, 53 W Third Ave, PO Box 8130, Columbus OH 43201-0130.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Fax: _____ E-Mail: _____

Section 1: Retired/Semi-Retired Rates (If retirement is due to disability/financial, complete Section 2 only)

_____ Retired rate * $50 I hereby certify that, on (date) _____, I retired completely from practice and am not gainfully employed in any phase of professional activity related to the field of osteopathic medicine. I further certify that I have been a member of the OOA for at least 10 years prior to retirement and I, therefore, petition the Board of Trustees of the Ohio Osteopathic Association to grant "Retired Status" for OOA membership. I further verify that my date of birth is: _____.

_____ Semi-Retired rate * $250 I hereby certify that I am semi-retired and working 20 hours or less in any phase of professional activity related to the field of osteopathic medicine. I further verify that I have been a member of the OOA for 10 consecutive years or more. I, therefore, petition the Board of Trustees of the Ohio Osteopathic Association to grant "Semi-Retired Status" for OOA membership.

Date: _____ Signature: _____

Section 2: Reduced Rate Due to Physical Disability or Financial Hardship

I hereby petition the OOA Board of Trustees for Reduced Dues in the following category (check one):

_____	Totally disabled, unable to engage in any substantial gainful activity	None
_____	Disabled/part-time practice limited to 20-30 hours per week	$100 *
_____	Disabled/practice restricted to less than 20 hours per week	$50 *
_____	Financial hardship	Discretion of the board *

My disability is (check one): _____ Permanent _____ Temporary

On the back of this form, please state the reason(s) for your request and describe the nature of your disability. If the reason is financial, please indicate the amount of dues you are willing and able to pay or the length of time you need a waiver.

I hereby certify the above information to be true. I further agree to notify the board of any change in my disability or financial status which might affect my dues status.

Date: _____ Signature: _____

*All categories become eligible for life membership at age 70 or after 50 years of active practice if you have had 25 consecutive years of membership.