

DOUGHERTY COUNTY MEDICAL SOCIETY

Membership Application

Please return to **Medical Society Box** at Phoebe Putney Hospital or mail to: P.O. Box 1828 Albany, Georgia 31702-1878

PRACTICE STATUS: ACTIVE RETIRED:

NAME: (Last) _____ (First) _____ (Middle) _____ SSN: _____

NAME OF EMPLOYER or PRACTICE NAME: _____

EMAIL ADDRESS: _____ WEB ADDRESS: _____

BUSINESS ADDRESS: _____

NAME OF PRACTICE ADMINISTRATOR: _____

BUSINESS PHONE: _____ (EXT) _____ HOME PHONE: _____ CELL PHONE: _____

HOME ADDRESS: _____

PREFERRED MAILING ADDRESS: HOME OFFICE

I AM A MEMBER OF : (MAG) Membership #: _____ (AMA) Membership #: _____

OUR PRACTICE IS ACCEPTING: NEW PATIENTS PATIENTS OVER 65 MEDICAID MEDICARE

DATE OF BIRTH: _____ SEX (M/F) _____ NAME OF SPOUSE: _____

PRIMARY SPECIALTY: _____ SECONDARY SPECIALTY: _____

BOARD CERTIFICATIONS: _____

GEORGIA LICENSE NO: _____ DATE FIRST LICENSED: _____

PRACTICE TYPE: _____ DESCRIPTION IF OTHER: _____
(1) solo, (2) group, (3) hospital based, (4) teaching/research, (o) other

GEORGIA SPECIALTY SOCIETY MEMBERSHIPS: _____

RESTRICT DISTRIBUTION OF YOUR BUSINESS ADDRESS FROM: (CIRCLE YES or NO)

1. Medically Related Profit Organizations **(Yes / No)** 2. Medically Related Non-Profit Organizations **(Yes / No)**

MEDICAL EDUCATION:

School: _____ Location: _____ Degree: _____ Date: _____

RESIDENCIES:

_____ Date: _____

_____ Date: _____

_____ ECFMG#: _____

EXPECTED RESIDENCY PROGRAM COMPLETION DATE: (if resident) _____

FELLOWSHIP: _____ DATE: _____

HOSPITAL AFFILIATIONS: 1.) _____ 2.) _____ 3.) _____

TEACHING APPOINTMENTS: _____ DATE: _____

DATE: _____

MILITARY: Branch _____ Dates: _____ Rank: _____

Branch _____ Dates: _____ Rank: _____

PREVIOUS STATE MEDICAL SOCIETY MEMBERSHIPS: _____

ARE YOU A CURRENT AMA MEMBER? YES _____ NO _____ LAST YEAR-PAID: _____

Within the last 5 years, have you been convicted of a felon crime? YES _____ NO _____ If yes, please provide full details

Within the last 5 years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?

YES _____ NO _____ If yes, please provide full information. _____

Within the last 5 years, have you been the subject of any disciplinary action by any medical society or hospital staff?

YES _____ NO _____ If yes, please provide full information. _____

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the Dougherty County Medical Society, the Medical Association of Georgia and the American Medical Association.

I hereby release, and hold harmless from any liability or loss, the Dougherty County Medical Society, and the Medical Association of Georgia, their officers, agents, employees, and members, for act performed in god faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualification for membership.

County Sponsor's Signature*

Applicant's Signature

County Sponsor's Signature*

***** FOR COUNTY USE ONLY *****

APPLICATION

APPROVED BY: _____

CERTIFIED BY: _____

DATE OF ACTION: _____

*If you have any questions regarding sponsors, please contact the DCMS at (229) 436-8191 or info@dc-ms.org