Membership Application

Please return to Medical Society Box at Phoebe Putney Hospital or mail to: P.O. Box 3770 Albany, Georgia 31706-3770

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: ____

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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

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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

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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 2015