



Membership Application

PERSONAL INFORMATION (please print or type)

Last Name First Middle Gender: Male Female Date of Birth: FL Medical License #: NPI #: Spouse's Full Name: Alliance Member Yes No Name of OCMS Member that recruited you:

MAILING INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at OFFICE HOME

Office Address Home Address Office City/State/Zip Home City/State/Zip Office Phone Home Phone Office FAX Home FAX Office Email Address Home Email Address Office Website Other Website Practice/Group Name: Administrator Name: Email Address: Practice Type: Solo Group Employed Government Based Academic Other Primary Specialty: Secondary Specialty:

EDUCATION

Medical School: City, ST: Graduation Date: Degree: MD DO Residency: Location Program Dates: Internship: Location Program Dates: Fellowship: Location Program Dates:

BOARD CERTIFICATIONS

1. Name of Board: _____

Certified in _____ Date: _____

2. Name of Board: _____

Certified in _____ Date: _____

HOSPITAL AFFILIATIONS

1. Hospital (Primary) _____ City: _____

2. Hospital _____ City: _____

3. Hospital _____ City: _____

MEMBERSHIP APPLICATION & QUALIFICATION QUESTIONS

Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign and date. If you answer yes to any of these questions, please attach full information.

Yes No

Have you ever been convicted of fraud or a felony?

Yes No

Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.

Yes No

Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society.

The foregoing information is true and complete.

Signature Date

PAY BY CREDIT CARD (OPTIONAL)

Visa Master Card American Express

Name on Card: _____

Amount: \$ _____

Card #: _____

Exp. Date _____

Signature: _____

Select Membership Rate

- | | |
|--|----------|
| <input type="checkbox"/> Active | \$360.00 |
| <input type="checkbox"/> Government/Retired | \$52.00 |
| <input type="checkbox"/> Resident/Intern/Student | \$13.50 |

The endorsement, deposit or negotiation of an applicant's check does not constitute admission into or acceptance of membership by the OCMS. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a check refunding the amount sent in.

Please Return Application and Membership Dues to:
Orange County Medical Society
901 N. Lake Destiny Rd., Ste 385
Maitland, FL 32751

Phone: 407-622-8188 Fax: 407-622-4614
www.ocms.org