**MEMBERSHIP APPLICATION**





***RETURN TO:***

**Alachua County Medical Society Forida Medical Association**

235 SW 2nd Avenue P.O. Box 10269

Gainesville, FL 32601-625 Tallahassee, FL 32302

(352) 376-0715 (800) 762-0233

 (352) 376-0811 FAX (850) 222-8030

Full Name (Print): Last First Middle

AMA Medical Education # FL Medical License #  M.D.  D.O.

Address: Please check beside address you wish to be used for membership records and mailings.

 \_\_\_ Primary Office Address City Zip Code

 Phone Fax E-mail Address

 Home Address

Phone Fax E-mail Address Home Page

Sex: Male Female Date of Birth : / / Spouse’s Full Name:

Practice Type: Solo Group Employed Government Based Academic Other

Practice/Group Name Administrator

**EDUCATION INSTITUTION LOCATION DEGREE/SPECIALTY DATES**

Medical School

Internship

Residency

Fellowships

Other Post Graduate

Specialty: Primary Secondary

**BOARD CERTIFICATIONS: DATE CERTIFIED DATE RE-CERTIFIED**

Name of Board Certified in Year Month Year Month

**HOSPITAL AFFILIATIONS:**

Hospital (Primary) City

Hospital City

Hospital City

Do you wish the local medical society to refer patients to you?  Yes  No

**MEMBERSHIP IN MEDICAL ORGANIZATIONS:**

Have you ever been a member of the FMA?  Yes  No County Medical Society

Are you a member of the American Medical Association?  Yes  No

Are you a member of your specialty organization ?  Yes  No

Name of FMA member that recruited you (if applicable)

Have you ever been convicted of a felony or misdemeanor, or held for violation of Federal or State narcotic laws; or the illegal use or sale of drugs? Yes  No (If yes, please provide full information.)

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?  Yes  No

Have any disciplinary actions ever been taken regarding your hospital privileges or medical society membership?  Yes  No

By my signature, I agree to accept and be bound by the Articles of Incorporation and Bylaws of the Association, and the Principle of Medical Ethics of the AMA, together with all future amendments of such Articles of Incorporation, Bylaws or Principles of Medical Ethics which may be duly adopted by the respective organizations.

I, hereby release, and hold harmless from any liability or loss, the Medical Society, their officers, agents, employees, and members, for acts performed in good 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 qualifications for membership. 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 Society.

I hereby certify that the foregoing is true and correct to the best of my knowledge. I understand and agree that if I knowingly make a false representation in this application, or a representation that in the exercise of reasonable care I should have known to be false, the FMA and/or component medical society has the authority to reject this application.

Signature Date

The endorsement, deposit or negotiation of an applicant’s check does not constitute admission into or acceptance of membership by the ACMS or FMA. 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.