



ACADEMY OF MEDICINE OF CINCINNATI

2300 Wall Street • Suite F • Cincinnati, OH 45212-2794
513-421-7010 • Fax 513-721-4378 • www.academyofmedicine.org



OHIO STATE MEDICAL ASSOCIATION

MEMBERSHIP APPLICATION

(Please print or type)

First Name Middle Last Name MD/DO

Date of Birth Birthplace Spouse Name

Practice/Group Name Web Address

Primary Office Address City State Zip Code
(If you have secondary addresses, please attach a separate list.)

Primary Office Telephone Office Fax Office E-Mail

Home Address City State Zip Code

Home Telephone Home Fax Home E-Mail

Preferred Mailing/Billing Location: Office Home Gender: Male Female

Primary Specialty Board Certification Secondary Specialty Board Certification

Medical School Graduation Date Internship Years Attended

Residency(ies) Years Attended Fellowship Years Attended
(If you have more than one, please attach a separate list.)

Current Hospital Affiliations

If accepted as a member, I agree to abide by the Academy of Medicine and the Ohio State Medical Association Articles of Incorporation and Code of Regulations. I understand and agree that by providing my address, email(s), telephone numbers(s), and fax number(s), I consent to receive communications sent by or on behalf of the Academy of Medicine and/or the Ohio State Medical Association via regular mail, email, telephone, or fax. By signing I agree to the terms and conditions listed here.

Signature: _____ Date: _____

• Please complete 2nd side of application •

Internal Use Only – Academy of Medicine of Cincinnati Approval	
Name _____ <small>Please Print</small>	Title _____
Signature _____	Date _____

Membership Category (Dues amount shown is for Academy membership only)

- | | | | |
|---|----------|--|---------------|
| <input type="checkbox"/> Active (Previous Member) | \$399.00 | <input type="checkbox"/> Associate | \$195.00 |
| <input type="checkbox"/> Active (New/1st Year) | \$199.00 | <input type="checkbox"/> Affiliate | \$75.00 |
| <input type="checkbox"/> Active Part-time (<20 hrs./wk) | \$197.50 | <input type="checkbox"/> Post-Graduate Trainee | \$30.00 |
| <input type="checkbox"/> Non-Resident | \$195.00 | <input type="checkbox"/> Student | Complimentary |

Refer to the Dues Information sheet for an explanation of categories.

Membership Choice

- Academy of Medicine of Cincinnati only
- Joint Membership: Academy of Medicine of Cincinnati & Ohio State Medical Association
[Active (Previous) members add \$560.00; Active New/1st Year or Active Part-time add \$280.00; and Resident add \$30.00]
- Ohio State Medical Association only
- Academy Foundation Donation (contributions to the Foundation are tax-deductible)

I am adding a gift in the amount of \$_____ to my membership dues.

Payment Options

- Check enclosed (make checks payable to the Academy of Medicine of Cincinnati)
- Charge to VISA MasterCard American Express Discover

Account # _____ Expiration Date _____

Name as it appears on the card _____

Cardholder's Street Address _____

City/State/Zip _____

Cardholder's Signature _____ Phone _____

Amount to be charged \$ _____

Payment arrangements are available and can be made by calling the Membership Department at 513-421-7010.

***If paying by check, return the completed application and check by mail to Academy of Medicine
Membership Department, 2300 Wall St., Suite F, Cincinnati, OH 45212-2794.***

If paying by credit card, you may return the application by mail or fax to 513-721-4378.