



# ACADEMY OF MEDICINE OF CINCINNATI

ACADEMY FOUNDATION • MEDCHEK/CREDENTIALS KEEPERS

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## Postgraduate Trainee Membership Application

*Please type or print legibly.*

Name \_\_\_\_\_ Gender \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City, State, Zip

Phone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Birth Date \_\_\_\_\_ Birth Place \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Medical Education \_\_\_\_\_  
School Location Degree / Year Earned

I am a (check one)  Resident  Fellow at:

Place Dates Specialty

License(s) \_\_\_\_\_  
Number State Date Issued

Number State Date Issued

I anticipate entering practice in the year \_\_\_\_\_.

If accepted as a member, I agree to abide by the Academy of Medicine of Cincinnati Articles of Incorporation and Code of Regulations. I understand and agree that by providing my address, e-mail, telephone number and fax number, I consent to receive communications sent by or on behalf of the Academy of Medicine of Cincinnati via regular mail, e-mail, telephone, or fax. By signing I agree to the terms and conditions above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Membership Dues:**  Academy: \$30.00/year  Ohio State Medical Association [optional]: \$30.00/year

Total amount: \$ \_\_\_\_\_  Check enclosed (payable to the Academy of Medicine of Cincinnati)

Charge my:  VISA  MasterCard  Discover  American Express

Account # \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name/billing address for credit card (if different than above) \_\_\_\_\_

•Return to the Academy of Medicine by mail or fax. Form may also be completed online at [www.academyofmedicine.org](http://www.academyofmedicine.org).•

2300 Wall Street • Suite F • Cincinnati, Ohio 45212-2794  
Academy of Medicine 513-421-7010 • FAX 513-721-4378 • MedChek/Credentials Keepers 513-721-4377

**For Internal Use Only: Academy of Medicine of Cincinnati Approval**

Name: \_\_\_\_\_ Office/Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_