



JOINT MEMBERSHIP APPLICATION



Academy
of Medicine
of Cincinnati

OHIO STATE MEDICAL ASSOCIATION ACADEMY OF MEDICINE OF CINCINNATI

320 Broadway • Cincinnati, OH 45202 • 513-421-7010 • Fax 513-721-4378

____ I am also interested in membership in the American Medical Association

Membership Category:

___ Active, Full-Time ___ Part-Time (<20 hrs./week)

___ Resident ___ Non-Resident* ___ Associate*

(Please print or type)

*Academy of Medicine only

INTERNAL USE ONLY

Med. Ed. # _____ County _____

First Name _____ Middle _____ Last Name _____ MD/DO _____

Date of Birth _____ Birthplace _____ Naturalization Date/Loc. (if applicable) _____

Practice/Group Name _____

Primary Office Address _____ City _____ State _____ ZIP Code _____

Primary Office Telephone _____ Office Fax _____ Office E-Mail _____

Home Address _____ City _____ State _____ ZIP Code _____

Home Telephone _____ Home Fax _____ Home E-Mail _____
Preferred Mailing Location: Office Home Gender: Male Female

Spouse Name _____

Medical Licensure

Ohio License No. _____ Expiration Date _____

Have you been or are you currently licensed in another state/province? If yes, please provide locations, numbers and dates.

State/Province License No. State/Province License No. State/Province License No.

Medical Education

Medical School _____ City _____ State _____ Graduation Date _____

Internship - Institution _____ City _____ State _____ Dates _____ Specialty _____

Residency - Institution _____ City _____ State _____ Dates _____ Specialty _____

Residency - Institution _____ City _____ State _____ Dates _____ Specialty _____

Fellowship - Institution _____ City _____ State _____ Dates _____ Specialty _____

Primary Practice Specialty _____ Board Certification _____

Secondary Practice Specialty _____ Board Certification _____

Current Specialty Society Membership(s) _____

Past County/State Medical Society Membership(s)

Current Hospital Appointments (names, location, dates)

Previous Hospital Appointments (names, locations, dates)

Has your license to practice medicine in any jurisdiction ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a licensing agency; or have you ever surrendered your license?

Yes. Please explain
No

Please initial the line next to each statement to confirm agreement and sign below.

I hereby certify that I am a legally registered physician, residing or practicing in the County of ... in the State of ... and that I have not been convicted of a felony. If accepted as a member, I agree to abide by the Constitution and Bylaws of my county medical society and the Ohio State Medical Association, and the Principles of Medical Ethics of the American Medical Association printed below.

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. The following Principles adopted by the American Medical Association are not laws but standards of conduct which define the essentials of honorable behavior for the physician.

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
II. A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
IV. A physician shall respect the rights of the patient, of colleagues and other health professionals and shall safeguard patient confidence within the constraints of the law.
V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use talents of other health professionals as indicated.
VI. A physician shall, in the provision of appropriate patient care except emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

I understand that conviction of fraud or a felony, or actions involving revocations, suspension, limitation, probation, or any other sanctions or conditions imposed upon a license to practice or disciplinary action by any other medical society or hospital staff, after due notice and hearing, may result in censure, suspension or expulsion of a member. The Health Care Quality Improvement Act requires professional societies to report certain professional review actions that adversely affect membership, including denial of membership, to the National Practitioner Data Bank.

I understand and agree that the receipt of any membership dues by the county medical society or the OSMA, which may accompany this application for membership, does not constitute acceptance of my application of membership. I understand and agree that I shall not be considered a member of the county medical society and the OSMA until formal action is taken on my application for membership. I understand and agree that any benefit of membership initiated during the application period shall be terminated if my application is not approved. I understand and agree that if my application for membership is rejected for any reason, I shall be entitled to a full refund of any dues paid to the county medical society or the OSMA.

I understand that additional information may be requested by the county medical society in order to complete the application process.

Signature Date

County Medical Society Approval

Name Office/Title

Signature Date