



# ACADEMY OF MEDICINE OF CINCINNATI

7265 Kenwood Road • Suite 315 • Cincinnati, OH 45236-4411  
513-421-7010 • Fax 513-721-4378 • www.academyofmedicine.org

## MEMBERSHIP DUES INFORMATION/APPLICATION

### Academy of Medicine of Cincinnati Membership Categories

*Please check appropriate membership category, select a payment option, and complete application on reverse side.*

**ACTIVE:** Any physician who has a current MD/DO license to practice issued by the State Medical Board of Ohio.

- Previous Member** — Physicians who held previous Active membership in the Academy. [\$399.00]
- New/First Year Member** — Physicians with no prior Academy Active membership history. [\$199.00]
- Part-Time Member** — Physicians with a current MD/DO license to practice issued by the State Medical Board of Ohio and practicing less than twenty (20) hours per week. [\$199.00]
- RETIRED:** Previous member who is no longer practicing (zero hours). Academy member benefits continue. [\$50.00]
- NON-RESIDENT:** Any physician holding a current license to practice medicine, who conducts the major portion of his or her practice outside of Hamilton County, Ohio. [\$195.00]
- POST-GRADUATE TRAINEE:** Any physician who has a current certificate or license issued by the State Medical Board of Ohio and is enrolled in an approved internship, residency, or fellowship program. [First year, complimentary; subsequent years, \$30.00]
- ASSOCIATE:** Allied health practitioners holding a current license to practice in Ohio. [\$195.00]
- AFFILIATE:** Individuals interested in the work of the Academy who are not eligible for other Academy membership, including those holding an executive/management position in a hospital or other health care facility. [\$75.00]
- STUDENT:** Any person who is enrolled in an approved college of medicine pursuing the degree of MD/DO. [Complimentary]

*If you have any questions about the membership categories, please contact the Academy at 513-421-7010.*

### Payment Options

- Check enclosed (make checks payable to the Academy of Medicine of Cincinnati)  Send Invoice

Charge to  VISA  MasterCard  American Express  Discover

Account # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on credit card \_\_\_\_\_ Amount charged \$ \_\_\_\_\_

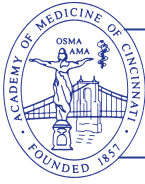
Cardholder Address \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_ Phone \_\_\_\_\_

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,  
7265 Kenwood Road, Suite 315, Cincinnati, OH 45236-4411.*

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



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## MEMBERSHIP APPLICATION

*(Please print or type. Complete items applicable to your membership category.)*

\_\_\_\_\_  
First Name                                      Middle                                      Last Name                                      MD/DO/Other

Male     Female

\_\_\_\_\_  
Date of Birth                                      Medical School                                      Graduation Date (actual or expected)

\_\_\_\_\_  
Home Address                                      City                                      State                                      Zip Code

\_\_\_\_\_  
Home/Cell Phone                                      Preferred Email Address

### Active/Non-Resident/Associate/Affiliate Members

Independent     Employed

\_\_\_\_\_  
Practice/Group Name                                      Web Address

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

\_\_\_\_\_  
Primary Office Telephone                                      Office Fax

\_\_\_\_\_  
Primary Specialty                                      Board Certification                                      Secondary Specialty                                      Board Certification

**Preferred Mailing/Billing Location:**     Office     Home

### Post-graduate Trainee Members

I am a  Resident  Fellow. I anticipate entering practice in the year \_\_\_\_\_.

\_\_\_\_\_  
Training Facility                                      Dates                                      Specialty

### All Membership Categories

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, email(s), telephone numbers(s), and fax number(s), I consent to receive communications sent by or on behalf of the Academy of Medicine of Cincinnati via regular mail, email, telephone, or fax. By signing, I agree to the terms and conditions listed here.

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

*• Please complete both sides of the application. Questions, call 513-421-7010. •*

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