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

Date of Birth ❑ Male ❑ Female | 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

Practice/Group Name ❑ Independent ❑ Employed | 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. •

Internal Use Only – Academy of Medicine of Cincinnati Approval

Name _____ Title_____
Please Print

Signature_____ Date_____