

MEDICAL ASSOCIATION OF THE STATE OF ALABAMA

Membership Application

I want to apply for membership through the _____ County Medical Society.
Yes, I also want to join the American Medical Association (AMA).

Regular []
Resident []
Student [] Date Graduation _____

PERSONAL INFORMATION

Last Name Suffix First Name Middle Name Degree Gender

Home Address City State Zip

Home Phone Fax Email Birthdate SS# (Student's Only)

PROFESSIONAL PRACTICE INFORMATION (if applicable)

Medical School Location Date AMA ME# (if known)

Alabama State License Date of Issue Other State Licenses Primary Specialty Sub-Specialty Sub-Specialty

Company Name

Office Address Line 1 Office Address Line 2

City State Zip

Work Phone Fax Email

Preferred Mailing [] Office [] Home Hospital Affiliation: _____

MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

If you answer yes to any of these questions, please attach full information.

- 1. Have you ever been convicted of fraud or a felony?
2. Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine?
3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I hereby release, and hold harmless from any liability or loss the _____ County Medical Society, and the Medical Association of the State of Alabama, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I agree to abide by the code of ethics of the American Medical Association as modified by the Medical Association of the State of Alabama.

Applicant's Signature Date

I am aware that the information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

Active Society Member Endorsement

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or

Active Society Member Endorsement

THE MEDICAL SOCIETY OF MOBILE COUNTY, INC.
APPLICATION FOR MEMBERSHIP ADDENDUM

A. Please list the names and telephone numbers of 3 physicians (preferably, members of the Medical Society of Mobile County) as references for your application:

1. _____

2. _____

3. _____

B. Married? ___ Yes ___ No If Yes, Spouse Name _____

C. Please attach your CV to this application.

D. Please attach a recent photograph for our website. You may submit a scanned photograph via email to msomc@earthlink.net.

E. In the wake of Hurricane Katrina, we discovered that we need additional emergency contact information from our physicians for disaster response. This information is kept strictly confidential. Please provide:

Cell Phone Number _____

Pager or Beeper Number _____

Alternate Phone Number _____

Email _____

Please complete in full and return to:

The Medical Society of Mobile County
2701 Airport Boulevard
Mobile, AL 36606-2319

Our Phone Number is: 251-476-9494

Our Fax Number is: 251-476-9495