



Membership Enrollment Kit
OHIO STATE MEDICAL ASSOCIATION
County Medical Society

Membership Category: [] Active, Full-Time
[] Part-Time (<20 hrs./week)

Internal Use Only
Med. Ed. # _____ County _____

(Please make corrections and/or additions as needed)

First Name _____ Middle _____ Last Name _____ [] DO
[] MD
Date of Birth _____ Birthplace _____ Naturalization Date/Loc. (if applicable) _____

Office Information

Practice/Group Name _____ Group Contact/Administrator _____
Office Address _____ City _____ State ____ Zip _____
Office Phone _____ Office Fax _____ Office E-Mail _____

Home Information

Home Address _____ City _____ State ____ Zip _____
Home Phone _____

Preferred Mailing Location [] Office [] Home Gender [] Male [] Female Spouse _____

Medical Licensure Ohio License No. _____ Expiration Date _____

Medical Education

Medical School _____ Grad Date _____
Internship-Institution _____ Specialty _____
City _____ State ____ Dates _____
Residency-Institution _____ Specialty _____
City _____ State ____ Dates _____
Residency-Institution _____ Specialty _____
City _____ State ____ Dates _____
Fellowship-Institution _____ Specialty _____
City _____ State ____ Dates _____
Primary Specialty _____ Board Certification _____

Medical Society/Hospital Affiliations

Current Specialty Society Membership(s) _____
Past County/State Medical Society Membership(s) _____
Current Hospital Appointments (names, location, dates) _____
Previous Hospital Appointments (names, location, 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

American Medical Association Membership

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

Terms and Conditions

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.

By signing I agree to the terms and conditions listed above.

I understand that by providing my address, email(s), telephone number(s), and fax number(s), I consent to receive communications sent by or on behalf of the Ohio State Medical Association, the Ohio Medical Education Foundation, the OSMA Insurance Agency, the Ohio Medical Association Political Action Committee (OMPAC), and/or a component county medical society of the OSMA via regular mail, email, telephone, or fax.

Signature: _____ Date: _____

Internal Use Only: County Medical Society Approval

Name _____ Office/Title _____

Signature _____ Date _____