

APPLICATION FOR MEMBERSHIP
COLUMBUS MEDICAL ASSOCIATION
OHIO STATE MEDICAL ASSOCIATION



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

Membership Category:

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

INTERNAL USE ONLY
 Med. Ed. # _____ County _____

(Please print or type)

First Name	Middle	Last Name	MD/DO
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Date of Birth	Birthplace	Naturalization Date/Loc. (if applicable)
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Practice/Group Name	Practice/Office Manager
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Primary Office Address	City	State	ZIP Code
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Primary Office Telephone	Office Fax	Office E-Mail
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Home Address	City	State	ZIP Code
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Home Telephone	Home Fax	Home E-Mail
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Preferred Mailing Location: Office Home Gender: Male Female

Spouse Name _____

Medical Licensure

Ohio License No.	Expiration Date
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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.
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Medical Education

Medical School	City	State	Graduation Date
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Internship - Institution	City	State	Dates	Specialty
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Residency - Institution	City	State	Dates	Specialty
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Residency - Institution	City	State	Dates	Specialty
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Fellowship - Institution	City	State	Dates	Specialty
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Primary Practice Specialty	Board Certification
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Secondary Practice Specialty	Board Certification
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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.

_____ 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*.

_____ 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 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 _____

RELEASE AND CONSENT

As a person (1) licensed to practice medicine in the State of Ohio; and (2) holding a degree of Doctor of Medicine or Doctor of Osteopathic Medicine or some foreign degree in medicine regarded by the Ohio State Medical Board as equivalent thereto; I hereby apply for membership in the Columbus Medical Association.

All information submitted in my application including the Application for Membership and this Addendum (collectively, the "Application") is true to my best knowledge and belief. I fully understand that any misstatement in, or omissions from, my Application may constitute cause for denial of or loss of, membership in the Columbus Medical Association.

I hereby release from any and all liability and agree not to sue the Columbus Medical Association, its officers, directors, employees, authorized representatives and agents, committees, members of committees, and any third parties providing information to the Columbus Medical Association for their acts performed in good faith and without malice in obtaining and verifying information contained in my Application and any attachments hereto, evaluating my Application and providing any recommendations, reports, statements, communications or other disclosures involving me. This authorization includes the right to inspect or obtain any and all documents, recommendations, reports, statements or disclosures relating to my Application. I also authorize third parties to release information to the Columbus Medical Association and its authorized representatives.

The term "Columbus Medical Association and its authorized representatives" shall mean (1) Columbus Medical Association; (2) members of Columbus Medical Association's Board of Directors, its committees, and members of its committees; and (3) Columbus Medical Association's officers, employees, agents and designees.

The term "third parties" means all individuals and entities from whom information has been or is requested by the Columbus Medical Association or its authorized representatives or who have requested such information from the Columbus Medical Association and its authorized representatives including but not limited to Practitioner Credential Verification Center (PCVC), physicians, health care practitioners, professional liability carriers, governmental agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, and data banks.

I understand and agree that this release and consent is irrevocable. I understand and agree that I, as an applicant for membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications for membership. I also acknowledge responsibility for timely payment of membership dues and understand that my Application is not a guarantee that I will be selected as a member of the Columbus Medical Association. I agree to provide written notification of changes to the information in my Application within thirty (30) days of the change to the Columbus Medical Association.

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. If your application is denied because of professional competency, the Columbus Medical Association will report the denial to the National Practitioner Data Bank.

A photocopy of this release and consent shall be as effective as the original when so presented.

Signature:

Date:

It is suggested that all applicants submit a personal photograph suitable for inclusion on our Physician Locator on our website and a current copy of his/her Curriculum Vitae with this Application.

Please return the completed "Application" to **Membership Division, Columbus Medical Association, 431 East Broad Street, Columbus, Ohio 43215**. Phone (614) 240-7410.