



Resident and Fellow Membership Application

For CMS use only: Date Recv'd. _____ Date Comp. _____ IMIS# _____

For TMA use only: ME# _____ IMIS# _____ RC _____

I will arrive in: _____ on: _____
County Date

BIOGRAPHICAL DATA	<input type="checkbox"/> Resident <input type="checkbox"/> Fellow <input type="checkbox"/> Intern Date of Birth _____ <input type="checkbox"/> Male <input type="checkbox"/> Female																																		
	Name: Last _____ First _____ Middle _____ Suffix _____ Degree _____																																		
	<input type="checkbox"/> Office Address (check if this is your preferred contact address) City _____ State _____ Zip _____																																		
	Phone _____ Fax _____ E-mail _____																																		
	<input type="checkbox"/> Home Address (check if this is your preferred contact address) City _____ State _____ Zip _____																																		
	Phone _____ Fax _____ E-mail _____																																		
	Texas Medical License# _____ UPIN# _____ SSN# _____																																		
Marital Status _____ Spouse's Name _____ If married, is spouse also a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No																																			
EDUCATION	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Institution</th> <th style="width:30%;">Address</th> <th style="width:10%;">City</th> <th style="width:10%;">State</th> <th style="width:10%;">Zip</th> <th style="width:10%;">Degree</th> <th style="width:10%;">Grad. Date</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>							Institution	Address	City	State	Zip	Degree	Grad. Date																					
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Residency Facility																																			
FORMAL DISCIPLINARY ACTION (Required)			Yes	No																															
	Have you ever had an application for membership in a medical society rejected?		<input type="checkbox"/>	<input type="checkbox"/>																															
	Have you ever been convicted of a crime, other than a non-felony motor vehicle violation?		<input type="checkbox"/>	<input type="checkbox"/>																															
	Has your medical license ever been revoked or suspended?		<input type="checkbox"/>	<input type="checkbox"/>																															
	Have you ever been subjected to disciplinary action by any of the following?																																		
		Board of Medical Examiners	<input type="checkbox"/>	<input type="checkbox"/>																															
	County/State Medical Society	<input type="checkbox"/>	<input type="checkbox"/>																																
	Hospital Medical Staff	<input type="checkbox"/>	<input type="checkbox"/>																																
<p><i>Note: completion of this section is required.</i></p>																																			

SIGNATURES & AUTHORIZATIONS (A COPY SHALL SERVE AS ORIGINAL)

I hereby apply for membership in the _____ County Medical Society and Texas Medical Association and, if accepted, agree to abide by and be subject to terms and conditions of the Constitution and Bylaws of the Society and of the Texas Medical Association and the Principles of the Medical Ethics of the American Medical Association.

In consideration of the _____ County Medical Society processing my application for membership, I grant permission and consent for you to obtain from any appropriate source all relevant information concerning my credentials and qualifications.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character, and ethical qualifications to all hospitals, medical discipline boards, and medical licensure boards which request such information.

I hereby release, and hold harmless from liability or loss, the _____ County Medical Society, the Texas Medical Association, and any other County Medical Society to which I transfer, 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 their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I understand that if my application for membership is denied by the Board of Censors, I have a right to appeal the denial to the County Medical Society pursuant to the Hearings Procedure Manual. I also understand that if my application for membership is denied, based on professional competence or conduct, the County Medical Society must report such a professional review action to the National Practitioner Data Bank through the Texas State Board of Medical Examiners within 15 days of the date that all due process rights have been exhausted.

I also agree that biographical information will be disseminated in accordance with the policy and procedures established by the TMA Council on Communication unless otherwise directed by me.

Signature (required) _____ Date _____

PAYMENT INFORMATION

A physician becomes a member of the district medical society and the Texas Medical Association when joining the county medical society, since the county society is a component organization chartered by the Association. Twenty dollars of TMA active membership dues is for a one year subscription to *Texas Medicine*. Dues paid to the county society and Texas Medical Association are not deductible as charitable contributions for Federal Income Tax purposes. A portion of dues may be deductible as ordinary and necessary business expenses.

- Check (make payable to Texas Medical Association)
- Credit Card: Visa Mastercard Discover

Name as it appears on card _____

Credit card number _____ Exp. date _____

Signature (required) _____

PLEASE SUBMIT PAYMENT WITH MEMBERSHIP APPLICATION

TMA Membership

AMA Membership

- Single-Year Membership\$45
 - Three-Year Membership\$120
- Save up to 12.5% with a multi-year discount*

APPROVAL OF BOARD OF CENSORS

FOR STAFF USE ONLY

We, your Board of Censors, have had the above application under consideration, and: Approve or Disapprove on _____ Date _____

Signature and Title

Signature and Title