



TMA/Dallas County Medical Society Membership Application

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

Membership Type: Resident Active Military Associate

I will arrive in: _____ on _____
County Date

BIOGRAPHICAL DATA	Name: Last	First	Middle	Suffix	Degree	Gender
	<input type="checkbox"/> Office Address (check if this is your preferred contact address)		Street	City	State	ZIP
	Phone	Fax	E-mail			
	<input type="checkbox"/> Home Address (check if this is your preferred contact address)		Street	City	State	ZIP
	Phone	Fax	E-mail			
	Date of Birth	Texas Medical License#	UPIN#	SSN#		
	Marital Status	Spouse's Name	<input type="checkbox"/> Yes <input type="checkbox"/> No If married, is spouse also a physician?			
	Company Name	Company Address				

SPECIALTY DESIGNATION	ECFMG # _____ Specialty: _____ Primary Secondary
	BOARD CERTIFICATIONS:
	Specialty Board Name Certification Date

PRIMARY PRACTICE	<input type="checkbox"/> Direct Patient Care	<input type="checkbox"/> Administration (non-clinical)	<input type="checkbox"/> Not in Patient Care	<input type="checkbox"/> Intern
	<input type="checkbox"/> Direct Patient Care and Teaching	<input type="checkbox"/> Full Time Teaching (non-clinical)	<input type="checkbox"/> Military	<input type="checkbox"/> Resident
	<input type="checkbox"/> Direct Patient Care and Research	<input type="checkbox"/> Research (non-clinical)	<input type="checkbox"/> Veterans Administration	<input type="checkbox"/> Fellow
	<input type="checkbox"/> First Year in Practice			

EDUCATION	Institution	Address	City	State	Zip	Degree	Grad. Date
	_____	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____	_____

POST GRADUATE TRAINING	Address	City	State	Zip	Specialty	Inclusive Dates
	Internship Facility	_____	_____	_____	_____	_____
	Residency Facility	_____	_____	_____	_____	_____
	Residency Facility	_____	_____	_____	_____	_____
	Other Post Graduate Training	_____	_____	_____	_____	_____

PREVIOUS PRACTICE	Organization	City	State	Zip	Inclusive Dates	Reason for Leaving
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

HOSPITAL AFFILIATIONS	Hospital	City	State	Zip	Type of Appt.	Inclusive Dates
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

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"/>

SIGNATURES & AUTHORIZATIONS (A COPY SHALL SERVE AS ORIGINAL)	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>I also agree that biographical information will be disseminated in accordance with the policy and procedures established by the TMA Board of Trustees unless otherwise directed by me.</p> <p>Signature (required) _____ Date _____</p>
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APPROVAL OF BOARD OF CENSORS	<p>We, your Board of Censors, have had the above application under consideration, and: <input type="checkbox"/> Approve or <input type="checkbox"/> Disapprove on _____ Date _____</p> <p>_____</p> <p>Signature and Title</p> <p>_____</p> <p>Signature and Title</p> <p>_____</p> <p>Signature and Title</p> <p>_____</p> <p>Signature and Title</p> <p>Note: Membership becomes effective when application has been approved and dues have been paid to the Association.</p>
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PAYMENT INFORMATION	<p>TEXAS MEDICAL ASSOCIATION 401 West 15th St. Austin, TX 78701-1680 (880) 880-1300 Fax: (512) 370-1693</p> <p>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. \$20 of TMA active membership dues is for a one year subscription to <i>Texas Medicine</i>. 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.</p> <p><input type="checkbox"/> Check (make payable to Texas Medical Association)</p> <p><input type="checkbox"/> Credit Card: <input type="radio"/> Visa <input type="radio"/> Mastercard</p> <p>Name as it appears on card _____</p> <p>Credit card number _____ Expiration date _____</p> <p>Signature (required) _____</p> <p style="text-align: center;">PLEASE SUBMIT PAYMENT WITH MEMBERSHIP APPLICATION</p>
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