TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

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: _____ (County) **on:** _____ (Date).

BIOGRAPHICAL DATA

☐ Resident ☐ Fellow ☐ Intern Date of Birth_____ ☐ Male ☐ Female

Name: Last First Middle Suffix Degree

☐ Office Address *(check if this is your preferred contact address)* City State Zip

Phone Fax E-mail

☐ Home Address *(check if this is your preferred contact address)* City State Zip

Phone Fax E-mail

Texas Medical License# NPI# SSN#

Marital Status Spouse's Name ☐ Yes ☐ No If married, is spouse also a physician?

EDUCATION

Institution	Address	City	State	Zip	Degree	Grad. Date

POST GRADUATE TRAINING

Institution	Address	City	State	Zip	Specialty	Inclusive Dates
Internship Facility						
Residency Facility						

FORMAL DISCIPLINARY ACTION (Required)

	Yes	No
Have you ever had an application for membership in a medical society rejected?	☐	☐
Have you ever been convicted of a crime, other than a non-felony motor vehicle violation?	☐	☐
Has your medical license ever been revoked or suspended?	☐	☐
Have you ever been subjected to disciplinary action by any of the following?		
Board of Medical Examiners	☐	☐
County/State Medical Society	☐	☐
Hospital Medical Staff	☐	☐

Note: completion of this section is required.

TEXAS MEDICAL ASSOCIATION 401 West 15th St. Austin, Texas 78701-1680 (800) 880-7955 FAX (512) 370-1693

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 Board of Trustees 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

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