Gregg Upshur County Medical Society

PHYSICIANS CARING FOR TEXANS

Texas Medical Association

TMA/Gregg Upshur 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: _____ (County) on _____ (Date).

BIOGRAPHICAL DATA

Name: Last First Middle Suffix Degree Gender

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

Phone Fax E-mail

☐ 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#

☐ Yes ☐ No

Marital Status Spouse's Name If married, is spouse also a physician?

SPECIALTY DESIGNATION

ECFMG #_____ Specialty: Primary _____ Secondary _____

BOARD CERTIFICATIONS:

Specialty	Board Name	Certification Date

PRIMARY PRACTICE

☐ Direct Patient Care
☐ Direct Patient Care and Teaching
☐ Direct Patient Care and Research
☐ First Year in Practice
☐ Administration (non-clinical)
☐ Full Time Teaching (non-clinical)
☐ Research (non-clinical)
☐ Not in Patient Care
☐ Military
☐ Veterans Administration
☐ Intern
☐ Resident
☐ Fellow

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?

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Has your medical license ever been revoked or suspended?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

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 qualficiations, 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_____

APPROVAL OF BOARD OF CENSORS

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

_____
Signature and Title

_____
Signature and Title

_____
Signature and Title

_____
Signature and Title

Note: Membership becomes effective when application has been approved and dues have been paid to the Association.

PAYMENT INFORMATION

Gregg Upshur County Medical Society **P.O. Box 934** **Gilmer,TX 75644** **903-725-5252** **Fax: 903-725-5252**

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 *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 neccessary business expenses.

Check (make payable to Texas Medical Association)

Credit Card: Visa Mastercard

Name as it appears on card _____

Credit card number _____ Expiration date_____

Signature (required) _____

PLEASE SUBMIT PAYMENT WITH MEMBERSHIP APPLICATION