

The Memphis Medical Society



Membership Application

I hereby make application for membership in the Memphis Medical Society and the Tennessee Medical Association.

Personal Information

First: _____ Middle: _____ Last: _____ MD DO
 Birth Date: ____ / ____ / ____ Place of Birth: _____ Male Female
 Social Security Number: _____ Spouse's Name (if applicable): _____
 TN Medical License #: _____ Date of Issue: ____ / ____ / ____ NPI # _____
 Language(s) spoken: _____

Contact Information (Please check the preferred mailing address for Medical Society correspondence.)

Primary Office Practice/Group Name: _____
 Street/P.O. Box: _____
 City: _____ State: _____ Zip: _____
 Telephone: _____ Fax: _____

Office #2 Practice/Group Name: _____
 Street/P.O. Box: _____
 City: _____ State: _____ Zip: _____
 Telephone: _____ Fax: _____

Home Address Street/P.O. Box: _____
 City: _____ State: _____ Zip: _____
 Home phone: _____ Cell phone: _____
 Pager: _____ Home Fax: _____
 Email Address: _____

Education and Post-Graduate Training

Names of Institutions, locations and states in chronological order

Pre-Medical School: _____
Name of Institution, Location, Dates, Degree

Medical School: _____
Name of Institution, Location, Dates, Degree

Internship/Post Graduate: _____
Name of Institution, Location, Dates, Degree

Residency _____
Fellowship _____
Name of Institution, Location, Specialty, Dates

Residency _____
Fellowship _____
Name of Institution, Location, Specialty, Dates

Specialty and Board Certifications

Specialty: _____

Sub-Specialty: _____

Board Certification and Year: _____

Organizational Involvement

Previous Medical Society Membership:

Society	City, State	Inclusive Dates
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Primary Specialty Society Membership:

Society	City, State	Inclusive Dates
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Hospital Staff Affiliations (List all hospitals in which you have active status.)

(1) _____ (3) _____

(2) _____ (4) _____

Other Information

Have you ever been convicted of a felony crime? Yes No
If yes, please provide full information.

Has your license to practice medicine in any jurisdiction been limited, suspended or revoked? Yes No
If yes, please provide full information.

Have you been the subject of any disciplinary action by any medical society or hospital staff? Yes No
If yes, please provide full information.

Do you want patient referrals from the Society? Yes No



We encourage you to apply for membership
in the **American Medical Association**
at this time by simply checking this box.



In signing this application, I agree that all statements are true and complete to the best of my knowledge and belief. If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and By-Laws of the component medical society, the Tennessee Medical Association and the American Medical Association. I hereby release and hold harmless from any liability or loss the component medical society to which I am applying, the Tennessee Medical Association, its 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, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership.

Signature of Applicant _____ Date _____

Please return ALL of the following:
(1) COMPLETED APPLICATION
(2) PAYMENT (see enclosed payment schedule)
(3) CURRENT CV
(4) REPRODUCIBLE PHOTOGRAPH

To: **The Memphis  Medical Society**

Attn: Membership Department
1067 Cresthaven Road
Memphis, TN 38119
(901) 761-0200