ISMA
INDIANA
STATE
MEDICAL
ASSOCIATION

APPLICATION FOR MEMBERSHIP
Monroe/Owen County Medical Society
Indiana State Medical Association

Name: Last/First/Middle M.D./D.O.

Apply using this form or go online to www.ismanet.org/join

Home	**Office**
Street	Practice Name
Street 2	Practice Manager
Street 3	Street
City, State, Zip	City, State, Zip
Phone	Phone
Fax	Fax
Email	Email

Please indicate preferred mailing address for ISMA mailings: ❑ Home ❑ Office

Gender
❑ M ❑ F Date of Birth City, State of Birth

Maiden Name *(if applicable)* Indiana License Number

NPI Number Spouse's Name: Last/First/Middle (indicate if M.D./D.O.)

Primary Specialty Board Certified (Year)

Secondary Specialty Board Certified (Year)

Hospital Affiliation(s)

Fellowship Program Name and Location Begin/End (MM/YY)

Residency Program Name and Location Begin/End (MM/YY)

Residency Program Name and Location _____ Begin/End (MM/YY) _____

Medical School Program Name and Location _____ Year of Graduation _____

Military Service – Branch _____ Dates of Service _____

Are you currently accepting:
Medicare patients? ❑ Yes ❑ No Medicaid patients? ❑ Yes ❑ No Medicare assignment? ❑ Yes ❑ No

Foreign languages spoken: _____

_____

Are you practicing as (check all that apply):

Practice Size	**Practice Type**	**Employed**
❑ Solo	❑ Education ❑ Patient Care ❑ Research	❑ Self ❑ Group/Network ❑ Hospital
❑ Group/Network	❑ Other_____	❑ Other_____

Other medical society memberships _____

Please read and sign

Renewal of your county, state and district memberships will be due by January 15th of each calendar year. An optional contribution to the Indiana Medical History Museum may also be included.

If dues payment is not included with this application, the Indiana State Medical Association (ISMA) will forward a dues invoice. Medical Association dues (except for specific governmental affairs expenses) may be deductible as professional or business expense to the extent allowable by law. Dues and other contributions to the ISMA and any county or district society are not deductible as charitable contributions for federal income tax purposes.

Certain work and professional information may be disseminated for public use: office address and phone numbers, specialties and board certifications, NPI numbers, medical school of graduation and graduation date. Any additional information you supply will be used in aggregate only.

If admitted to this society, I will faithfully observe all its rules and regulations, do all in my power to further its interest and the profession, and observe the Principles of Medical Ethics of the AMA and Rules of the Council on Ethical and Judicial Affairs. I hereby give permission to the Credentials Committee of any hospital to release information deemed necessary for membership in the medical society.

_____ _____
Physician Signature Date

Thank you. To see all the benefits of membership, visit www.ismanet.org/benefits.

Return to Indiana State Medical Association, Membership, 322 Canal Walk, Indianapolis, IN 46202
Phone (800) 257-4762 or (317) 261-2060 • www.ismanet.org

DUES PAYMENT INFORMATION

ISMA Dues $490.00
Monroe/Owen Co Medical Society.....$200.00
Total Membership Dues.....$690.00

Voluntary Contribution:
Medical Museum $35 (suggested)

Dues vary for first year in practice and by county.
See www.ismanet.org/join for specific dues information.

Method of Payment: **Total amount paid:**
] Check (Payable to ISMA) $_____
] Visa] MasterCard] American Expess

Account # _____

Expiration Date _____

CCV# (3-digit code)_____

Signature _____

MONROE
OWEN COUNTY
MEDICAL SOCIETY
P.O. BOX 5092, BLOOMINGTON, INDIANA 47407-5092, TELEPHONE (812) 332-4033

Please complete the following forms and ATTACH A PICTURE for MOCMS use.
Mail to: Monroe Owen County Medical Society, P.O. Box 5092, Bloomington, IN 47407-5092

Start date in Monroe/Owen Counties _____ **Spouse email** _____

Are you accepting new patients? □ **Yes** □ **No**

_____ **Yes, I would like to receive the MOCMS Newsletter by email.**

In applying for membership in the Monroe Owen County Medical Society, I release from any liability all individuals and organizations who provide information to the society in good faith and without malice concerning my competence, ethics, character and other qualifications for membership privileges.

If admitted to this society, I will faithfully observe all its rules and regulation, do all in my power to further its interests and the profession and observe the Principles of Medical Ethics of the American Medical Association and the Rules of the Council on Ethical and Judicial Affairs.

_____

Physician Signature month/day/year

_____

County Society Officer month/day/year

PLEASE NOTE

The following information may be disseminated for public use:

- Office Address and Phone Numbers
- Specialties and Board Certifications
- Medical School of Graduation and Graduation Date

Any additional information supplied will be used for statistical purposes ONLY.

Monroe Owen Medical Society
Information Release Form

The MOCMS office requests your permission to publish your home address, phone number, personal email and spouse's name and email in the physician membership directory. **Distribution of this directory is limited to physician members.**

Name _____

_____I give my permission to release information as described.

_____I do not give my permission to release information as described.

Signature _____Date _____