Click Here & Upgrade
Expanded Features
Unlimited Pages
PDF Complete

PERSONAL INFORMATION

Please Type or Print

________________________________ ________________ Male or Female

Place of Birth (City, State) Date of Birth

____ ______ - ________ - ________

Spouse Name (please include title if applicable) Social Security Number

HOME address:

____

Street City, State, Zip

( )________________________________ ( )________________________________

Home Phone Home FAX

____

E-Mail

PROFESSIONAL INFORMATION

SPECIALTY
*****Only the primary specialty will be listed in the ISMA directory*****

Primary ____Board Certified (Year)_________

Secondary ______________________________________ Board Certified (Year)_________

ADDRESSES and PHONE NUMBERS

PREFERRED ADDRESS: OFFICE ________ HOME ________
(please check one)

List your **PRIMARY OFFICE** address:

____

Street City, State, Zip

( )________________________________ ( )________________________________

____

Office Phone Office FAX

____________________________________ ( )________________________________

E-Mail Beeper Number

Corporation Name:____

Office Manager:____

Previous Practice Location:____

____

Click Here & Upgrade
Expanded Features
Unlimited Pages
PDF Complete

____ ______________________

Military Service - Branch | Date Begun

Military Reserves: Yes ____________ No _____________ ______________________

Date Completed

____ ______________________

Medical School | Year Of Graduation

____ ______________________

Residency | Year Began/Completed (expected completion)

____ ______________________

Residency | Year Began/Completed (expected completion)

____ ______________________

Fellowship | Year Began/Completed (expected completion)

_____________ ____________________ _______________

Year of IN License | Indiana License Number | UPIN/NPI Number (National Provider Identification)

_____________ ____________________

CSR # | Federal DEA #

Are you currently accepting:

Medicare Patients? YES NO

Medicaid Patients? YES NO

Medicare Assignment? YES NO

Foreign Languages:

____

____

____

Primary Employment (check one):

_____Solo _____Group Practice _____Employed by hospital _____Other

Network ____

(Name of Network)

____ Resident - 1st Year

____ Resident - Other Years

____ Clinical Fellow

____ Research Fellow

____ Administration

____ Medical Teaching

____ Medical Research

Who recruited you to the County/ISMA Medical Societies? ____________________________________

Previous medical society memberships:____

National and state specialty society memberships:____

____

Hospital Affiliations:

____ ____________________________________

____ ____________________________________

Click Here & Upgrade
Expanded Features
Unlimited Pages
PDF Complete

Please read the following, sign and return.

If admitted to this society, I will faithfully observe all its rules and regulations, 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. 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**

County Office Use Only

______________________________ ______________

County Society Officer Date

______________________________ ______________

County Society Officer Date

Note Number of signatures may vary by county

PLEASE NOTE

The following information may be disseminated for public use:
Office Address and Phone Numbers
Specialties and Board Certifications
UPIN Numbers
Medical School of Graduation and Graduation Date

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

Within 30 days of receipt of the approved application from your county medical society, the ISMA will forward a dues statement. Thereafter, renewal of your county, state, and district memberships will be due by January 15th of each calendar year. As a convenience, you may remit your AMA dues along with your ISMA and county dues. Optional contributions to the Indiana Medical Political Action Committee (IMPAC) and the Indiana Medical History Museum may also be included.

In most cases, medical association dues (except for specific governmental affairs expenses) may be deductible as professional or business expenses to the extent allowable by law. Dues and other contributions to the Indiana State Medical Association the American Medical Association, any county society and district society, and IMPAC are not deductible as charitable contributions for federal income tax purposes. In addition, no portion of any dues paid to AMPAC or IMPAC can be deducted as a business expense on your federal income tax return.

Click Here & Upgrade
Expanded Features
Unlimited Pages
PDF Complete

APPLICATION FOR MEMBERSHIP

State, County and District Medical Societies

Adams
Bartholomew/Brown
Benton
Boone
Carroll
Cass
Clark
Clay
Clinton
Daviess-Martin
Dearborn/Ohio
Decatur
DeKalb
Delaware/Blackford
DuBois
Elkhart
Fayette/Franklin
Floyd
Ft. Wayne (Allen)
Fountain/Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison/Crawford
Hendricks
Henry
Howard
Huntington
Indianapolis (Marion)
Jackson
Jennings
Jasper/Newton
Jay
Jefferson/Switzerland
Johnson
Knox
Kosciusko
LaGrange
Lake
LaPorte
Lawrence
Madison
Marshall
Miami
Monroe Owen
Montgomery
Morgan
Noble
Orange
Perry
Pike
Porter
Posey
Pulaski
Putnam
Randolph
Ripley
Rush
St. Joseph
Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh
Vigo/Parke/Vermillion
Wabash
Warrick
Washington
Wayne/Union
Wells
White
Whitley
Resident Medical Society

____

LAST/FIRST/MIDDLE **MAIDEN** **M.D./D.O.**

____

COUNTY MEDICAL SOCIETY

____

DATE

ISMA OFFICE USE ONLY

ME #____ EFFECTIVE DATE: _____________

COUNTY CODE:________________ SPEC CODE:________

CLASS CODE: _____________

322 Canal Walk, Indianapolis, IN, 46202-3252 • (317) 261-2060 or 1-800-257-4762