APPLICATION FOR MEMBERSHIP

SUMMIT COUNTY MEDICAL SOCIETY

908 E Waterloo Road, Suite B, Akron, OH 44306 PHONE: 330.773-7267

Please complete and sign this application for membership in the Summit County Medical Society.

Membership Category: ☐ Active (Full-Time) ☐ Part-Time (<20 hrs/week)

NAME _____

GROUP NAME: _____

OFFICE ADDRESS: _____

OFFICE PHONE: _____ **FAX:** _____ **EMAIL:**_____

HOME ADDRESS, CITY & ZIP: _____

HOME PHONE: _____ **SPOUSE:** _____ **DATE OF BIRTH:** ___ _____

PREFERRED MAILING ADDRESS: ☐ HOME or ☐ OFFICE

MEDICAL EDUCATION AND TRAINING:

MEDICAL SCHOOL: _____ **YEAR OF GRADUATION:** _____

SPECIALTY: _____ **SUB-SPECIALTY:** _____

BOARD CERTIFIED: _____ **YEAR:** _____

Residency/Fellowship HOSPITAL/INSTITUTIONS CITY STATE: DATES

RESIDENCY: _____

MEDICAL LICENSURE:

STATE: OHIO CERTIFICATION NUMBER: ~~~~~~~~~~~~~~~~~~~~~~~~~ **EXPIRATION** ~~~~~~~~~~~~~~~~~~~~

PREVIOUS OHIO COUNTY MEDICAL SOCIETY MEMBERSHIP HELD IN 2010-2011 (if applicable)

_____

CURRENT HOSPITAL STAFFS ***(PLEASE CHECK ALL THAT APPLY):*** **☐ SUMMA ☐ AGMC ☐ Children's**

☐ Other (Please list) _____

Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a licensing agency; or have you ever surrendered your license? ☐ YES ☐ NO

I hereby certify that I am a legally registered physician, residing or practicing in Summit County in the state of Ohio and that I have not been convicted of a felony. If accepted as a member, I agree to abide by the Constitution and Bylaws of the SCMS and the OSMA, and the *Principles of Medical Ethics of the American Medical Association.*

SIGNATURE_____ ***DATE***_____