

Indianapolis (Marion County) Medical Society

631 East New York Street • Indianapolis, IN 46202-3706
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The mission of Indianapolis Medical Society is to promote professional growth, advocacy for all physicians, and quality health care for the community.

Membership Application

*Indianapolis Medical Society • Seventh District Medical Society
Indiana State Medical Association • American Medical Association*

Applicant's Name: _____ MD DO

Please Print Last First Middle Maiden

Primary Specialty: _____ Year Board Certified: _____

Subspecialties: _____ Year Board Certified: _____

I hereby certify that I am a legally registered physician with an unrestricted license, residing or practicing in Marion County or an adjoining county, in the State of Indiana, 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 my county medical society and the Indiana State Medical Association, and the Principle of Medical Ethics of the American Medical Association. **Please attach copies of current licenses and board certifications.**

Signature: _____ Date: _____

Personal Information

This information is for our records only. It will not be published in our Pictorial Roster.

Gender: M F Date of birth: / / Place of birth: Social Security: #

Marital Status: M S W D Spouse Name: Is your spouse a physician? MD DO

Home Address: City: State: Zip:

Phone: () Unlisted? Yes No Fax: () E-mail Address:

Practice Information

a) Preferred mailing address: Home Primary Secondary

b) Corporation/Practice Name: Office Contact: Phone: ()

c) Type of practice: Solo Group Corporation Hospital Other

d) Primary Office Address: Suite: # Phone: ()

City: State: Zip: Fax: ()

e) Secondary Office Address: Suite: # Phone: ()

City: State: Zip: Fax: ()

f) E-mail Address: Web Address:

g) Pager/Cell: Answering Service:

h) Check all practice information you want published in the Roster. Primary Office: Address Phone Fax Secondary Office: Address Phone Fax
 E-mail Address Web Address

Referral & License Information

a) Do you wish to be included on our free referral service for members? Yes No

b) Do you make housecalls? Yes No Existing patients only? Yes No

c) Medicare? Yes No Assignment? Yes No Medicaid? Yes No

d) List major health plans accepted. _____

e) List any foreign languages spoken, including sign language. _____

f) Do you give FAA physicals? Yes No ICC physicals? Yes No

g) Please list special areas of practice or unique services offered (e.g., laser surgery, sleep disorders). _____

h) Indiana License: # CSR: # Federal DEA: # NPI: #

Education & Training (Please attach CV, if available.)

Undergraduate: City: State: Zip: Country:

Medical School: City: State: Zip: Country:

Date Started: / / Date Completed: / / Degree Received: MD DO

ECFMG (if applicable): Issue Date: / /

Internship: City: State: Zip:

Specialty: Date Started: / / Date Completed/Expected: / /

Residency: City: State: Zip:

Specialty: Date Started: / / Date Completed/Expected: / /

Residency: City: State: Zip:

Specialty: Date Started: / / Date Completed/Expected: / /

Fellowship: City: State: Zip:

Specialty: Date Started: / / Date Completed/Expected: / /

Fellowship: City: State: Zip:

Specialty: Date Started: / / Date Completed/Expected: / /

(If additional space is needed, please supply information on a separate sheet.)

Hospital Affiliations (Please check all that apply.)

- | | | | | |
|---|---------------------------------------|---|--|---|
| Community: | Franciscan St. Francis Health: | IU Health: | St. Vincent: | <input type="checkbox"/> Hendricks Regional Health |
| <input type="checkbox"/> Community East | <input type="checkbox"/> Beech Grove | <input type="checkbox"/> Methodist | <input type="checkbox"/> Carmel | <input type="checkbox"/> Morgan Hospital & Medical Center |
| <input type="checkbox"/> Community North | <input type="checkbox"/> Mooresville | <input type="checkbox"/> North | <input type="checkbox"/> Heart Center of Indiana | <input type="checkbox"/> Riverview Hospital |
| <input type="checkbox"/> Community South | <input type="checkbox"/> South Campus | <input type="checkbox"/> Riley Hosp. for Children | <input type="checkbox"/> Indianapolis | <input type="checkbox"/> Roudebush VA Hospital |
| <input type="checkbox"/> The Indiana Heart Hospital | | <input type="checkbox"/> Simon Cancer Center | <input type="checkbox"/> Peyton Manning Children's Hospital at St. Vincent | <input type="checkbox"/> Westview Hospital |
| | | <input type="checkbox"/> University | <input type="checkbox"/> Women's Hospital | <input type="checkbox"/> Wishard Hospital |
| | | <input type="checkbox"/> West | | <input type="checkbox"/> Other(s) |

Sponsors

Please list two (2) Active members of the Society who have agreed to be your sponsors. We will send sponsor letters to them. Please call if you need to verify Members.

1. 2.

Membership Dues (Please make check payable to Indianapolis Medical Society.)

Call Tyna at 639-3406 to verify current membership dues. Discounts may apply through-out the year.	Membership	Total	Total	IMS	ISMA	District	AMA
		(without AMA)	(with AMA)				(Optional)
	Regular	\$720.00	\$1,140.00	\$325.00	\$385.00	\$10.00	\$420.00
	1st Year Practice	\$365.50	\$ 575.50	\$162.50	\$193.00	\$10.00	\$210.00
	Resident	\$ 50.00	\$ 95.00	\$ 0.00	\$ 50.00	\$ 0.00	\$ 45.00
Affiliate	\$ 325.00						

Checklist (Please review before returning form.)

- 1. I have enclosed a photograph for publication and file (optional).
- 2. I have enclosed copies of my current State Controlled Substances and medical license.
- 3. I have enclosed a copy of my current Federal DEA certificate.
- 4. I have enclosed a copy of my board certification certificate.
- 5. I have signed the application.
- 6. I have enclosed my membership fee (please make check payable to Indianapolis Medical Society).