

Indianapolis (Marion County) Medical Society

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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 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 It will not be published in our Pictorial Roster.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 MD DO

Home Address: _____

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) Answering Service: _____ Pager/Cell: _____

g) E-mail Address: _____ Web Address: _____

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:

Medical School: City: Country:

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

ECFMG (if applicable): Issue Date: / /

Internship: City:

Specialty: / / Date Completed/Expected: / /

Residency: City:

Specialty: / / Date Completed/Expected: / /

Residency: City:

Specialty: / / Date Completed/Expected: / /

Fellowship: City:

Specialty: / / Date Completed/Expected: / /

Fellowship: City:

Specialty: / / Date Completed/Expected: / /

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

Additional Information

a) Did someone other than the Medical Society contact you regarding membership? Yes No If so, please list name

Hospital Affiliations

- Clarian North Heart Center of Indiana Morgan Hospital & Medical Center St. Francis - South Campus VA Hospital
- Clarian West Hendricks Regional Health Riley Hospital St. Vincent - Indianapolis Westview Hospital
- Community East Indiana Heart Hospital Riverview Hospital St. Vincent - Carmel Wishard Hospital
- Community North Indiana University St. Francis - Beech Grove St. Vincent Children's Hospital Other(s)
- Community South Methodist Hospital St. Francis - Mooresville St. Vincent Women's Hospital

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)

Membership	Total (without AMA)	Total (with AMA)	IMS	ISMA	District	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).