Indianapolis (Marion County) Medical Society

631 East New York Street • Indianapolis, IN 46202-3706
Telephone (317) 639-3406 • Fax (317) 262-5609
E-mail: ims@imsonline.org

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

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.

Signature: Date:

Personal Information

This information is for our records only.

Gender: ❑ M ❑ F Date of birth: / / Place of birth:

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 on the website (imsonline.org) and in DocBookMD.

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: #

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:
- ❑ Community East
- ❑ Community North
- ❑ Community South
- ❑ Community Westview Hospital
- ❑ The Indiana Heart Hospital

Franciscan St. Francis Health:
- ❑ Indianapolis
- ❑ Mooresville
- ❑ South Campus

IU Health:
- ❑ Methodist
- ❑ North
- ❑ Riley Hosp. for Children
- ❑ Simon Cancer Center
- ❑ University
- ❑ West

St. Vincent:
- ❑ Carmel
- ❑ Heart Center of Indiana
- ❑ Indianapolis
- ❑ Peyton Manning Children's Hospital at St. Vincent
- ❑ Women's Hospital

- ❑ Hendricks Regional Health
- ❑ Morgan Hospital & Medical Center
- ❑ Riverview Hospital
- ❑ Roudebush VA Hospital
- ❑ EskenaziHospital
- ❑ 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.)

Membership	Total	IMS	ISMA	7th District
Regular	**$720.00**	$325.00	$385.00	$10.00
1st Year Practice	**$365.50**	$162.50	$193.00	$10.00
Resident	**$ 50.00**	$ 0.00	$ 50.00	$ 0.00
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).