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.

Resident/Fellowship 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:

Sub-specialty: Year Board Certified:

Personal Information

This information is for our records only. It will not be available to the public.

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:

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

Undergraduate: City: State: Zip: Country:

Medical School: City: State: Zip: Country:

Year Started: Year Completed: Degree Received: ❑ MD ❑ DO

ECFMG (if applicable): Year Issued:

Current Residency/Fellowship: (circle one)

Program Name: Program Coordinator: Phone: ( )

Street: City: State: Zip:

Specialty: Year Started: Year Completed:

Street: City: State: Zip:

Previous Residency Name & Location:

Specialty: Year Started: Year Completed:

Previous Residency Name & Location:

Specialty: Year Started: Year Completed:

License Information

Indiana License: # CSR: # Federal DEA: #

Membership Dues – Residency/Fellowship $ 50.00 (one time fee for entire length of residency/fellowship for IMS, ISMA, and 7th District)

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. **Please attach copies of current licenses and board certifications.**

Signature: Date:

Program Director's Signature: Date:

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 medical license.
❑ 3. My Program Director and I have signed the application.
❑ 4. Make Check Payable to Indianapolis Medical Society.