

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.

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.

