



19 South Jackson Street • Post Office Box 1900  
Montgomery, Alabama 36102-1900

Office Use Only:  
 Campaign Code: \_\_\_\_\_  
 App. Rec'd \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Dues Rec'd \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Dues Amt. \$ \_\_\_\_\_  
 Check # \_\_\_\_\_ CC \_\_\_\_\_  
 Approved Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Entered in DB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Entered by \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Copy to MASA \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Dues to MASA \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### MEMBERSHIP APPLICATION

Membership of MASA and the Medical Society of Mobile County are unified in accordance with Chapter 1, Section 1 of the Medical Association of Alabama Bylaws.

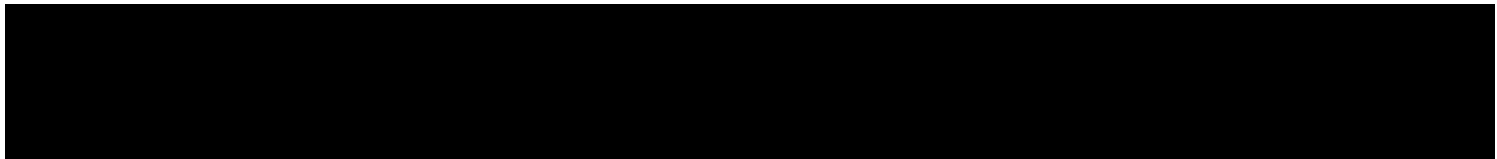
#### PERSONAL INFORMATION

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ ( ) \_\_\_\_\_ Informal  Degree  Gender   
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_ Birthdate \_\_\_\_\_ Spouse \_\_\_\_\_

#### PROFESSIONAL PRACTICE INFORMATION (if applicable)

Medical School \_\_\_\_\_ Location \_\_\_\_\_ Date \_\_\_\_\_ AMA ME# (if known) \_\_\_\_\_  
 Alabama State License \_\_\_\_\_ Date of Issue \_\_\_\_\_ Other State License \_\_\_\_\_ Date of Issue \_\_\_\_\_ Primary Specialty \_\_\_\_\_ Sub-Specialty \_\_\_\_\_ Sub-Specialty \_\_\_\_\_  
 Residency Location \_\_\_\_\_ Date Completed \_\_\_\_\_ Board Certification \_\_\_\_\_ Date \_\_\_\_\_  
 Fellow Location \_\_\_\_\_ Date Completed \_\_\_\_\_ Hospital Privileges: \_\_\_\_\_  
 Company Name \_\_\_\_\_ Office Administrator/Manager \_\_\_\_\_  
 Office Address Line \_\_\_\_\_ Office Address Line \_\_\_\_\_  
 City \_\_\_\_\_ Stat \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Fax \_\_\_\_\_ Cell or Alternate \_\_\_\_\_ Preferred Mailing  Office  Home  
 Email \_\_\_\_\_  Opt-out of Third Party Solicitations  
 Website \_\_\_\_\_  
 Employment Description: Solo  Group Practice -Employee  Group Practice -Partner  Health System Physician

*Over to complete Page 2*



# COUNTY MEDICAL SOCIETY SPECIFIC INFORMATION

Accepting New Patients?	YES	NO	Foreign Language spoken _____
Medicare	YES	NO	Foreign Language spoken _____
Medicaid	YES	NO	
Tricare	YES	NO	

**Please attached a recent photo for website purposes email photo to farmstrong@masalink.org**

**Please attached your CV to this application.**

**In the wake of Hurrigan Katrina, we discovered that we need additional emergency contact information from out physicians for disaster response. This information is kept strictly confidential. Please provide:**

Cell Phone Number \_\_\_\_\_

Pager or Beeper Number \_\_\_\_\_

Alternate Phone Number \_\_\_\_\_

Email \_\_\_\_\_

**Please list the names and telephone numbers of 3 physicians(preferably, members of the Medical Society of Mobile County) as references for your application.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

# MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

*If you answer yes to any of these questions, please attach full information.*

\_\_\_\_\_ 1. Have you ever been convicted of fraud or a felony?  
**YES**    **NO**

\_\_\_\_\_ 2. Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine?  
**YES**    **NO** This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.

\_\_\_\_\_ 3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?  
**YES**    **NO**

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society(ies). I hereby release, and hold harmless from any liability or loss the \_\_\_\_\_

County Medical Society, and the Medical Association of the State of Alabama, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I agree to abide by the code of ethics of the American Medical Association as modified by the Medical Association of the State of Alabama.

The foregoing information is true and complete

I am aware that the information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

\_\_\_\_\_  
**Applicant's Signature** **Date**