MEDICAL ASSOCIATION
OF THE STATE OF ALABAMA®

MEMBERSHIP APPLICATION

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. 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.

Member Type: ☐ Physician in Practice ☐ Resident/Fellow ☐ Medical Student

Practice Type: ☐ Solo ☐ Group ☐ Health System

Name and Personal Info:

First: _____ Middle: _____ Last: _____

Suffix: _____ Informal: _____ Birth Date: _____ Spouse: _____

Gender: ☐ Male ☐ Female ☐ Prefer not to answer AL Medical License # _____

Designation: ☐ MD ☐ DO ☐ Other: _____ License Issue Date: _____

Medical School: _____ Graduation year: _____ Specialty: _____

Residency Location: _____ Sub-Specialty(ies): _____

Address: (Please check preferred address)

Primary County of Practice: _____ Third-Party Solicitation Opt-Out: ☐ Yes

☐ Primary Office

Company: _____

Street/PO Box address: _____

City/State/Zip: _____

Office Phone: _____

Office Fax: _____

Office Email: _____
(Please provide an email unique to you, not a general practice email)

☐ Home

Street/PO Box address: _____

City/State/Zip: _____

Home Phone: _____

Cell Phone: _____

Personal Email: _____

How to Return/Complete your payment:

Mail: Medical Association of the State of Alabama
19 S Jackson St
Montgomery, AL 36104

Phone: 334-954-2500 (For Questions or Assistance)

Web: Apply and pay dues online at ALAMEDICAL.ORG

Email: Scan and send to awasden@alamedical.org.

Visit ALAMEDICAL.ORG to calculate your total annual membership dues or call us for additional assistance.

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.
The foregoing information is true and complete.

Applicant's Signature _____

Date _____