

OKLAHOMA STATE MEDICAL ASSOCIATION MEMBERSHIP APPLICATION



Return this completed application using any of the contact methods at the bottom to begin your membership.

PERSONAL INFORMATION

First Name _____ Last Name _____ Middle _____ Suffix _____

MD _____ DO _____ NPI # _____ Previous Names _____ Date of Birth _____

M _____ F _____ Spouse/Partner Name/NA _____ Other Languages _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Preferred Email _____

PRACTICE INFORMATION

Practice Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Practice Email _____ Fax _____

Practice Manager Name _____ Practice Manager Email _____

Practice Type Solo _____ Partnership _____ Small Group _____ Large Group (7+) _____

Employed _____ Academic _____ Administrative _____

Specialty _____ Secondary Specialty _____

OSMA MEMBERSHIP DUES

OSMA dues are \$300. Additional rural county prices range from \$5 to \$100. OK County is \$280, bringing membership dues to \$580. Tulsa County is \$380, bringing membership dues to \$680. County dues are required. **This only applies to the active category.**

Active _____ (OK MD/DO license and practicing 3+ yrs) **\$300** (1st yr practice \$150, 2nd yr practice \$225)

Military _____ (currently active duty) **\$0**

Affiliate _____ (MD/DO w/ no OK license) **\$100**

Affiliate Primary _____ (Non MD/DO physician for OSMA Health) **\$100** (\$25 each additional employee)

Additional and Recommended Membership Opportunities

American Medical Association _____ (Additional and Recommended) **\$420** (If selected, price added to OSMA dues)

AGREEMENT

I understand that by providing my contact information, I consent to receive communications from my County Society and OSMA. (email addresses of AMA members will be provided to the AMA). I, the undersigned applicant, hereby certify that I understand fully that membership in the Oklahoma State Medical Association and American Medical Association is a privilege and not a right. If this application is approved and I am accorded the privilege of membership, I hereby agree to abide by the provisions of the OSMA and AMA Constitution and Bylaws and to practice in accordance with the established usages of the profession, and endorse the Principles of Medical Ethics set forth by the American Medical Association.

Signature _____ Date _____

send invoice to practice address _____ send invoice to home address _____ send invoice to email _____