



Application for Membership Oklahoma State Medical Association American Medical Association

Information should be typed or written legibly in ink.

Applying for membership in the following organizations (check only one):

- Oklahoma State Medical Association (OSMA) and local County Medical Society
- American Medical Association (AMA), OSMA and local County Medical Society

Last Name	First Name	Middle Name	Suffix	Professional Designation
Sex	NPI #	ECFMG or Flex (if applicable)		AMA ME # (if known)
Date of Birth	Place of Birth	Marital Status		Spouse's Name (if applicable)

Licensed in Oklahoma by: Examination ____ Reciprocity ____ Oklahoma License # ____ Date ____

If by reciprocity, give state in which first license was issued: ____ Date ____

Date you began practice: ____ Is this your 1st year of practice ____ 2nd year ____

Preferred Address to Received Mail: Office: ____ Home ____

Provide the information below. Note: This information will be published in OSMA's printed and online directories.

Graduation Year ____ Medical School Name: ____

Primary Office Address: ____
Street City Zip Code

Office Phone: ____ Fax: ____
Area Code Number Area Code Number

E-Mail Address: ____ Website (if applicable): ____

Primary Specialty: ____ Board Certified in Primary Specialty: Yes ___ No ___
Certifying Board: ____ Date Certified: ____

Secondary Specialty: ____ Board Certified in Secondary Specialty: Yes ___ No ___
Certifying Board: ____ Date Certified: ____

Sub-Specialty: ____ Board Certified in Sub-Specialty: Yes ___ No ___
Certifying Board: ____ Date Certified: ____

Type of Practice: Solo ____ Partnership (1-2) ____ Small Group (3-6) ____ Large Group (7+) ____

Employed by Hospital ____ Employed by University ____ Other ____

Additional Credentials (i.e., JD, MPH, etc. : ____

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Please complete the following information (for OSMA use only – Information is not published.)

Cell Phone: _____ Home Phone: _____
Area Code Number Area Code Number

Pager #: _____
Area Code Number

Home Address: _____
Street City Zip Code

Foreign Languages Spoken (Include Sign Language): _____

ARMED SERVICES

Are you currently engaged in active military duty in any branch of the United State Armed Forces? If yes, please complete below:

Branch (Army, Navy, Air Force, Marines, U.S. Public Health) _____ Dates of Active Service _____

List all medical professional memberships and societies, including state and county medical societies.

Name of Organization	From	To
_____	_____	_____
_____	_____	_____
_____	_____	_____

Communication Consent Form

I understand that by providing my fax number and/or e-mail address, I consent to receive communications on OSMA and AMA advocacy initiatives, news for physicians and OSMA and AMA products and services. (E-mail 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.

Date: _____ Applicant's Signature: _____

The following information is for County Medical Society and OSMA use only

Approved by _____ County Medical Society or Oklahoma State Medical Association

Representative Signature: _____ Date: _____

Please return the completed application to:
Membership Coordinator, Oklahoma State Medical Association
313 N.E. 50th - Oklahoma City, OK, 73105
Fax: (405) 601-9575 or by e-mail to osma@okmed.org