OKLAHOMA STATE MEDICAL ASSOCIATION MEMBERSHIP APPLICATION

Return this application using any of the contact information at the bottom to begin your membership or visit my.okmed.org/med

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____________________________________ Ste #_____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 the Tulsa County Medical Society and the 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 Tulsa County Medical Society, 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 _____