## APPLICATION FOR MEMBERSHIP

## STARK COUNTY MEDICAL SOCIETY/Ohio State Medical Association 4942 Higbee Avenue, Suite L, Canton, Ohio 44718 PHONE: 330.492.3333

Please *complete* sign this application for membership in the Stark County Medical Society and the Ohio State Medical Association. Return it in the self-addressed envelope provided for your convenience. Thank you!

Membership Type:	[] Stark County [] OSMA	<b>L</b>		
Membership Category:	Active (Full-Time) Part-Time	e (<20 hrs./week)		
NAME:				
Medical Education #:				
GROUP NAME:				
OFFICE ADDRESS:				
OFFICE PHONE:	FAX:		EMAIL:	
HOME ADDRESS, CI	ГY & ZIP:			
HOME PHONE:				
SPOUSE:				
DATE OF BIRTH:				
PREFERRED MAILING ADDRESS: HOME or OFFICE				
<u>MEDICAL EDUCATIO</u>	<u> DN AND TRAINING:</u>			
MEDICAL SCHOOL:		YEAR C	OF GRADUATION:	
SPECIALTY:				
SUB-SPECIALTY:				
<b>BOARD CERTIFIED:</b>				
YEAR:				
Residency/Fellowship	HOSPITAL/INSTITUTIONS	<u>CITY</u>	STATE:	DATES
RESIDENCY:				
MEDICAL LICENSUK	<b>PF</b> .			
STATE:	<b>CERTIFICATION NUMBER :</b>		EXPIRATIO	DN:
PREVIOUS OHIO COUNTY MEDICAL SOCIETY MEMBERSHIP HELD IN 2011-2012 (if applicable)				

## **<u>CURRENT HOSPITAL STAFFS</u>** (PLEASE CHECK ALL THAT APPLY): ALLIANCE COMMUNITY AULTMAN AFFINITY MEDICAL CENTER MERCY MEDICAL CENTER

Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a licensing agency; or have you ever surrendered your license? YES NO

I hereby certify that I am a legally registered physician, residing or practicing in Stark County in the state of Ohio and that I have not been convicted of a felony. If accepted as a member, I agree to abide by the Constitution and Bylaws of the SCMS and the OSMA, and the Principles of Medical Ethics of the American Medical Association.

SIGNATURE\_\_\_\_\_ DATE\_\_\_\_\_

Please attach PHOTO for Pictorial DIRECTORY Or email your photo (pdf file) to starkmedical@ ameritech.net