APPLICATION FOR MEMBERSHIP

BUTLER COUNTY MEDICAL SOCIETY
7249 Liberty Way Suite 200
West Chester, Ohio 45069
info@butlercountymedicalsociety.org

Full Name (Please print) | Date of Birth | Birthplace

Practice/Group Name | Primary Office Address | City, State, Zip Code

Primary Office Telephone | Office Fax | Office E-mail

Second Office Address | City, State, Zip Code | Telephone | Fax

Home Address | City, State, Zip Code | Telephone | Spouse

Preferred Mailing Location: _____Office _____Home _____E-mail _____Male _____Female

Medical Education & Training

Medical School | City/State | Dates | Graduation Date

Internship-Institution | City/State | Dates | Specialty

Residency-Institution | City/State | Dates | Specialty

Residency-Institution | City/State | Dates | Specialty

Fellowship-Institution | City/State | Dates | Specialty

Primary Practice Specialty | Board Certification

Secondary Practice Specialty | Board Certification

Current Hospital Affiliations

Has your license to practice medicine 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

If yes, please explain: -

_____

_____

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

I understand that conviction of fraud or a felony, or actions involving revocations, suspension, limitation, probation or any other sanctions or conditions imposed upon a license to practice medicine or disciplinary action by any other medical society or hospital staff, after due notice and hearing, may result in censure, suspension or expulsion of a member. The Health Care Quality Improvement Act requires professional societies to report certain professional review actions that adversely affect membership, including denial of membership, to the National Practitioner Data Bank.

I understand and agree that the receipt of any membership dues by the Butler County Medical Society does not constitute acceptance of membership. I understand and agree that I shall not be considered a member of the Butler County Medical Society until formal action is taken on my application for membership. I understand and agree that any benefit of membership initiated during the application period shall be terminated if my application is not approved. I understand and agree that if my application for membership is rejected for any reason, I shall be entitled to a full refund of any dues paid to the Butler County Medical Society.

I understand that by providing my address, e-mail, telephone number and fax number, I consent to receive communications sent by or on behalf of the Butler County Medical Society and the Butler County Medical Society Foundation via regular mail, e-mail, telephone or fax.

I agree to the terms and conditions listed above.

_____Signature

_____Date

Butler County Medical Society Internal Use Only

Date Membership Approved: _____