

APPLICATION FOR MEMBERSHIP

BUTLER COUNTY MEDICAL SOCIETY

2820 Bobmeyer Rd., Hangar C7, Suite 111, Hamilton, OH 45015

513-887-1515 Fax 877-247-0287

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: _____