



APPLICATION FOR MEMBERSHIP

Oklahoma County Medical Society

Oklahoma State Medical Association & American Medical Association



Applying for Membership in (select one):

OCMS & OSMA

OCMS, OSMA, AMA

PERSONAL INFORMATION

Last _____ First _____ Middle _____ Suffix _____

Professional Designation MD DO Other Credentials _____ Male Female

Other Names Used _____ Birthdate _____ NPI Number _____

Marital Status _____ Spouse/Partner Name (if applicable) _____ Other Languages _____

Home Address _____ City _____ State _____ ZIP _____

Mobile _____ Home Phone _____ Email _____

Active Military Yes No If yes, branch? _____ Dates? _____ to _____

Preferred way to receive communications: Email Text Fax Office Mail Home Mail
Please check all that apply.

PROFESSIONAL INFORMATION

Group Practice Name _____

Address _____ City _____ State _____ ZIP _____

Email _____ Phone _____ Fax _____

Office Manager: Name _____ Phone _____ Email _____

Practice Type: Solo Partnership Small Group Large Group (7+)
 Please select all that apply. Employed Full Time Academic Administrative/Consultant

Primary Hospital _____ Date you began practice _____

Primary Specialty _____ Secondary Specialty _____

Medical School Name/Dates _____

Residency Name /Dates _____

Internship(s) Name/Dates _____

AUTHORIZATION & AGREEMENT

I understand that by providing my contact information, I consent to receive communications from OCMS and 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 Oklahoma County Medical Society and Oklahoma State Medical Association is a privilege. If this application is approved by the OCMS Board of Directors and I am accorded the privilege of membership, I hereby agree to abide by the provisions of the OCMS and OSMA 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.

Applicant Signature _____ Date _____

To complete your application: 1) Pay online at okcountymed.org/pay. 2) Email completed app: afink@okcountymed.org

To apply with enclosed check: Oklahoma County Medical Society, 313 NE 50th, Ste. 2 Oklahoma City, OK 73105

Questions? Call (405) 702-0500

For Office Use Only: Approved by OCMS Board of Censors _____ Date _____
 _____ Date _____