



TENNESSEE
MEDICAL
ASSOCIATION

Membership Application

I hereby make application for membership in the Tennessee Medical Association and the

Local Medical Society: _____

PERSONAL DATA

First: _____ Middle _____ Last _____

MD DO

Birth Date: _____ Male Female

SS# _____

TN Medical License # _____ Date of Issue: _____

Marital Status: Single Married Spouse Full Name _____

ADDRESS/COMMUNICATIONS INFORMATION (Please check the preferred address for TMA correspondence)

Primary Office Street/PO Box _____

City/St/Zip _____

Home Street/PO Box _____

City/St/Zip _____

Practice/Group Name _____

Email: _____

Office Phone 1 _____

Home Phone _____

Office Phone 2 _____

Office Fax _____

TRAINING

Specialty _____ Subspecialty _____

Board Certification(s) _____

Boards and Dates

Residency

Fellowship _____

Name of Institution, Location, Specialty, Degree

Residency

Fellowship _____

Name of Institution, Location, Specialty, Degree

Medical School _____

Name of Institution, Location, Graduation Date, Degree

MISCELLANEOUS

Have you ever been convicted of a felony? Yes No

Has your license to practice medicine in any jurisdiction been limited, suspended or revoked? Yes No

Have you ever been the subject of any disciplinary action by any medical society or hospital staff? Yes No

If yes to any of the above, please provide complete information on a separate sheet of paper.

AGREEMENT

In signing this application, I agree that all statements are true and complete to the best of my knowledge and belief. If elected to membership, I agree to conduct myself professionally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the component medical society, the Tennessee Medical Association and the American Medical Association. I hereby, release and hold harmless from any liability or loss the component medical society too which I am applying, the Tennessee Medical Association, its officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals, who, in good faith and without malice provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership.

Signature of Applicant

Date

Physician who asked you to join: _____

COMPONENT SOCIETY APPROVAL (office use only)

- Active, Full-time Practice
- First Year Of Practice Following Training
- Second Year Of Practice Following Training
- Resident
- Student

Signature for CMS Approval

Date

Payment

Please remit your completed application along with a check or credit card information to:

Tennessee Medical Association
ATTN: Membership Department
P O Box 120909
Nashville TN 37212-0909

Credit Card Information

*(For TMA purposes only)
(Fax to 615-312-1956)*

Please check one: Visa MasterCard Total \$ _____

CC# _____ - _____ - _____ - _____

Expiration Date _____ / _____ Billing Zip Code _____

Personal _____
Name as it appears on Credit Card

Corporate* _____
**If Corporate, name of corporation*