Orleans Parish Medical Society

Membership Application

PERSONAL INFORMATION

Last Name (as shown on medical license) | First Name | Middle Name | Degree (MD/DO) | Birthplace | Date of Birth (mm / dd / yy) | Gender (M/F)

Home Address | City | State | Zip Code

Telephone | Fax | Email Address | Marital Status | Spouse's Name

PROFESSIONAL PRACTICE INFORMATION (IF APPLICABLE)

Preferred Mailing Address ☐ Office ☐ Home

Louisiana License Number | Other State Licenses

Practice Name or Group (If Applicable) | Primary Specialty | Subspecialty

Primary Practice Address | City | State | Zip Code

Telephone | Fax | Email Address | Website

EDUCATIONAL INFORMATION

			From	To
Undergraduate College	Degree	Address, City, State, Zip	Month/Year	Month/Year
Medical School		Address, City, State, Zip	Month/Year	Month/Year
Internship (Hospital)	Specialty	Address, City, State, Zip	Month/Year	Month/Year
Residency (Hospital)	Specialty	Address, City, State, Zip	Month/Year	Month/Year
Fellowship	Specialty	Address, City, State, Zip	Month/Year	Month/Year

MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

Members abide by the bylaws of the Orleans Parish Medical Society. To assist us in upholding these standards, please provide answers to the following questions, sign and date.

If you answer yes to any of these questions, please attach full information.

Yes	No	
○	◉	Have you ever been convicted of fraud or a felony?
○	◉	Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any imposed sanctions or conditions.
○	○	Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society. The foregoing information is true and complete.

Signature | Date

PAYMENT

- ☐ Active Member $250.00
- ☐ Part Time Member... $150.00
- ☐ Students/Residents .... $ 0.00

Make check payable to Orleans Parish Medical Society

Mail to: Orleans Parish Medical Society
P.O. Box 24376
New Orleans, Louisiana 70184

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