



Joint Membership Application

MEMBERSHIP IS REQUIRED IN BOTH THE STATE AND LOCAL PARISH/COMPONENT MEDICAL SOCIETY. Please choose the parish/component medical society in whose jurisdiction where you maintain your residence or in whose jurisdiction where you maintain your principal office. Please indicate your choice of parish/component medical society: Orleans Parish Medical Society

TYPE OF MEMBERSHIP

- Active
- Active Part-Time (20 hrs. max./wk.)
- Service (Military/VA)
- Active 1st Year in Practice
- Academic (Asst. Professor or Above)
- Resident/Fellow – Completion Year: _____
- Active 2nd Year in Practice
- Academic (Below Asst. Professor)
- Medical Student – Completion Year: _____
- I would like to apply for AMA Membership. (If you are applying to the AMA, members abide by the AMA Principles of Medical Ethics.)

PERSONAL & PROFESSIONAL INFORMATION (PLEASE PRINT OR TYPE)

Full Name _____		Preferred Mailing Address: <input type="checkbox"/> Office <input type="checkbox"/> Home Preferred Email <input type="checkbox"/> Office <input type="checkbox"/> Home
Degree <input type="checkbox"/> MD <input type="checkbox"/> DO	Birth Date (____/____/____) Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single Spouse Name: _____		
Home Address _____		City _____ State _____ Zip _____
Home Phone (____) _____		Home Fax (____) _____ Home Email _____
Primary Specialty _____		Sub-Specialties _____
Specialty Areas of Expertise _____		
Board Certification(s) _____		Languages Spoken _____
Practice Name or Group Name _____		
Office Address _____		City _____ State _____ Zip _____
Office Phone (____) _____		Office Fax (____) _____ Office Email _____
Cell Phone (____) _____	Practice Administrator _____	
Practice Admin. Phone (____) _____	Practice Admin. Email _____	
Hospital Affiliations _____		
LA License # _____	Other State Licenses _____	ME# _____
Medical School _____	City/State _____	Year Received MD _____
Undergraduate _____	Degree _____	City/State _____ Dates Attended _____
Internship _____	Specialty _____	City/State _____ Dates Attended _____
Residency _____	Specialty _____	City/State _____ Dates Attended _____
Fellowship _____	Specialty _____	City/State _____ Dates Attended _____
Medical School Teaching Appointments _____		Professorship Level _____
Interested in serving as a Media Contact or as a Speaker? Media <input type="checkbox"/> Yes <input type="checkbox"/> No Speaker <input type="checkbox"/> Yes <input type="checkbox"/> No (If indicated yes, you will be contacted)		

Medicare Accepted:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Medicaid Accepted:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Workers Comp Accepted:	<input type="checkbox"/> YES <input type="checkbox"/> NO

SUPPLEMENTAL INFORMATION AND ATTESTATION

Members are governed by the Louisiana State Medical Society (LSMS) Principles of Medical Ethics and must comply with the bylaws of the LSMS and Parish Component Medical Society. To assist in upholding these standards, please provide answers to the following questions. 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 _____

If membership has been recommended to you by an LSMS member, please list his/her name here: _____

Applications are processed by the Parish/Component Medical Society. Additional information may be requested. Please return this application and applicable dues (payable to Orleans Parish Medical Society) to the LSMS, 6767 Perkins Rd, Ste 100, Baton Rouge, LA 70808. You may also join online at www.lsms.org.