

APPLICATION FOR OPMS/LSMS &/OR AMA MEMBERSHIPS: 2006

I want to join:

- OPMS & LSMS
 AMA

For 2006 only, OPMS & LSMS have approved waiver of dues due to hardship if the new member cannot pay the annual dues.

THREE EASY WAYS TO JOIN

PHONE:
504-523-2474, EXT. 3008
 FAX:
504-522-3325

MAIL:
Orleans Parish Medical Society
400 Poydras St., #1350
New Orleans, LA 70130

Check your preferred status

Personal Information:

Active Membership:
Reside or practice in Orleans Parish 20+ hours/week (\$650/yr.: OPMS/LSMS for >3-yrs. in practice) (\$325/1st; \$487.50/2nd) \$420/yr.: AMA

Part-Time Active Membership:
Practice/work less than 20 hrs/week Residing or practicing in Orleans Parish - \$325/yr. OPMS/LSMS \$210 - AMA

Associate Membership:
Instructors, medical school faculty below Asst. Professor; (\$325/year) Physicians retired to Louisiana (\$225/year)

Affiliate Membership:
Belong to another parish society/LSMS already, and want OPMS membership benefits (\$200/yr.)

Resident Member
(\$25 - OPMS/LSMS) (\$45 - AMA)

Student Member
(\$0 dues)

Payment of Dues Accepted by Check or Credit Card (MC/Visa/Discover). See invoice.

Membership Dues Enclosed:
\$ _____

Dues Waiver Requested

Name _____ Office FAX: _____
 Primary practice address _____ Office Telephone # _____
 URL Address _____ Email Address _____
 Home address _____ Home Telephone # _____
 Gender _____ Citizenship _____ Marital Status _____
 Social Security # _____ Birthdate _____ Birthplace _____
 Primary Specialty _____ Subspecialty _____ Name of Spouse _____
 Is your spouse interested in joining the Alliance (Spouses' organization)? Yes No

Education, Service Duty, Employment, Other:

Medical school _____ Address, City, State, Zip _____ Mo. & year _____ Mo. & year _____
 Internship(hospital) Specialty _____ Address, City, State, Zip _____ Mo. & year _____ Mo. & year _____
 Residency (hospital) Specialty _____ Address, City, State, Zip _____ Mo. & year _____ Mo. & year _____
 Fellowship Specialty _____ Address, City, State, Zip _____ Mo. & year _____ Mo. & year _____
 Military Branch _____ Where Stationed _____ Mo. & year _____ Mo. & year _____
 Previous practice (employer) _____ Address, City, State, Zip _____ Mo. & year _____ Mo. & year _____
 Current Hospital Affiliation(s) _____ Primary _____ Secondary _____
 Medical school teaching appointments _____ Professorship Level _____

Licensing Information:

Louisiana License# _____ Date Issued _____ Federal drug registration # _____ State drug registration # _____
 Other state(s) _____ Date Issues _____ License # _____ ECFMG# _____

Please answer the following questions: (If you answer "yes" to any of these questions, please provide an explanation on a separate sheet)

Has your license in any jurisdiction ever been restricted, suspended, revoked, or surrendered? Yes No
 Have you ever been refused membership in a medical society? Yes No
 Have you ever been the subject of disciplinary action by a medical society? Yes No
 Have you ever been convicted of a crime other than a minor traffic offense? Yes No

Attestation

Please read and sign

I agree to abide by the Charter, Bylaws, and Principles of Medical Ethics of the OPMS and LSMS. I will conduct my practice in accordance with the ideals, dignity, and accepted practices of the medical profession and will not promote or support practice on an unscientific basis. I am aware that information submitted in this application will be verified and additional information may be obtained by OPMS or LSMS. By applying for membership, I signify my willingness to OPMS/LSMS to consult with the organization, institutions, and individuals named in the application for the purpose of verifying the information. I understand and agree that I, as an applicant for membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any such doubts about those qualifications. I fully understand that any significant mis-statement in or omission from the application constitutes grounds for denial of application or cause for summary dismissal from the membership. Information submitted by me in this application is true and accurate to my best knowledge and belief.

Signature: _____ Date: _____

Practice Manager Information:

Name _____ Title _____ Direct Phone # _____

Was your practice manager responsible for recruiting you to join OPMS & LSMS? * Yes No

*By checking "yes", as a thank you, OPMS will pay for the dues for your practice manager to join LMGMA-GNO if he/she chooses.

2006 Dues Invoice - Submit to Orleans Parish Medical Society

Dues Amounts:

Dues Waiver Due to Hardship Requested for 2006

OPMS/LSMS Active Membership:
Reside or practice in Orleans Parish
\$650/yr.: OPMS/LSMS for 3or more years in practice)
(\$325/1st year in practice)
(\$487.50/2nd year in practice)

AMA Active Membership
\$420/year for physicians who have been practicing
3 or more years
(\$210/year/1st year in practice)
\$315/year/2nd year in practice)

Part-Time Active Membership:
Practice/work less than 20 hours/week
Residing or practicing in Orleans Parish
\$325/yr. OPMS/LSMS
\$210 - AMA

Associate Membership:
Instructors, medical school faculty below Asst.
Professor; (\$325/year)
Physicians retiring to Louisiana; (\$225/year)

Affiliate Membership:
Belong to another parish society LSMS already,
and want OPMS membership benefits (\$200/yr.)

Resident Member
(\$25 - OPMS/LSMS)
(\$45 - AMA)

Student Member/OPMS&LSMS
(\$0 dues)

TOTAL DUES ENCLOSED: \$ _____

Contributions/Assessments (Contributions/Assessments can be remitted on the same check)

OPMS' Greater New Orleans Medical Foundation \$25.00 Other: \$ _____

LSMS Education & Research Foundation \$10.00

TOTAL CONTRIBUTIONS ENCLOSED: \$ _____

TOTAL DUES AND CONTRIBUTIONS ENCLOSED: \$ _____

Processing Information:

If you have any questions concerning this invoice, please contact Susan D'Antoni at Orleans Parish Medical Society (504-523-2474) or by email at dantoni@opms.org.

If paying dues by credit card, please fax this information to 522-3325 with your completed application.

If paying by check, please mail the check and application to P.O. Box 54593, New Orleans, LA 70154.

We will gladly forward your LAMPAC contribution to the state office.

Payment Method: Check Credit Card

Credit Card to be Used: (Circle One) VISA Mastercard

Name as it appears on the card: (please print)

Account Number:

Expiration Date:

LAMPAC Membership (Louisiana Medical Political Action Committee)

Separate Personal Check Required for LAMPAC Membership

LAMPAC Regular \$200

LAMPAC Sustainer \$300

Total LAMPAC Contribution Enclosed in Separate Check: \$ _____

Federal law prohibits co-mingling of political contributions with dues.

We will gladly forward your LAMPAC contribution to the state office. See mailing instructions above.

Questions?

Contact: Susan D'Antoni, Executive Director
Orleans Parish Medical Society
400 Poydras Street, Suite 1350
New Orleans, LA 70130
504-523-2474
FAX 504-522-3325
Email: dantoni@opms.org

Alliance Organizations (Open to physicians' spouses)

If your spouse is interested in joining the Orleans Medical Society Alliance, please make check payable to OMSA and include with your dues. We will forward the dues and your spouse's information to the Alliance.

ACTIVE, ASSOCIATE, SPECIAL OR MEMBER-AT-LARGE:

- Orleans, Louisiana State, and AMA \$90
- Orleans, Louisiana State Only \$50
- Orleans Parish only \$30

JUNIOR (Resident, Intern, Medical Student Spouse)

- Orleans, Louisiana State, and AMA \$20
- Orleans, Louisiana State Only \$10
- Orleans Parish Only \$ 5