



ADDENDUM INDIANAPOLIS (Marion County) MEDICAL SOCIETY

Name: _____ MD/DO

Are you currently a member of the American Medical Association? Yes ___ No ___

Marital Status: M S W D Sex M F

PRACTICE INFORMATION:

a) OFFICE #2 (IF APPLICABLE) Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Email: _____ Answering Service: _____

b) Do you want the following published in the Roster? Fax: Yes ___ No ___ E-mail: Yes ___ No ___

REFERRAL INFORMATION:

a) Are you accepting new patients? Yes ___ No ___
If yes, do you wish to be included on our **free** referral service for members? Yes ___ No ___

b) Do you make house calls? Yes ___ No ___

c) List major health plan affiliations: _____

d) Do you give the following physicals? FAA: Yes ___ No ___ ICC: Yes ___ No ___

e) Please list special areas of practice or unique services offered (e.g., laser surgery, sleep disorders).

LICENSURE: *Please attach copies of current licenses.*

CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES:

a) List full name of specialty boards by which you are certified (*Please attach copies of current certificates.*):

_____ Date Certified: _____ Expiration: _____

_____ Date Certified: _____ Expiration: _____

HOSPITAL AFFILIATIONS:

- | | | |
|--|---|--|
| <input type="checkbox"/> Clarian North | <input type="checkbox"/> Indiana University | <input type="checkbox"/> St. Vincent - Indianapolis |
| <input type="checkbox"/> Clarian West | <input type="checkbox"/> Methodist Hospital | <input type="checkbox"/> St. Vincent - Carmel |
| <input type="checkbox"/> Community East | <input type="checkbox"/> Morgan Hospital & Medical Center | <input type="checkbox"/> St. Vincent Children's Hospital |
| <input type="checkbox"/> Community North | <input type="checkbox"/> Riley Hospital | <input type="checkbox"/> St. Vincent Women's Hospital |
| <input type="checkbox"/> Community South | <input type="checkbox"/> Riverview Hospital | <input type="checkbox"/> VA Hospital |
| <input type="checkbox"/> Heart Center of Indiana | <input type="checkbox"/> St. Francis - Beech Grove | <input type="checkbox"/> Westview Hospital |
| <input type="checkbox"/> Hendricks Regional Health | <input type="checkbox"/> St. Francis - Mooresville | <input type="checkbox"/> Wishard Hospital |
| <input type="checkbox"/> Indiana Heart Hospital | <input type="checkbox"/> St. Francis - South Campus | <input type="checkbox"/> Others _____ |

REFERENCES:

Please list two (2) Active Members of the Society who have agreed to be your sponsors. We will send sponsor letters to them. Please phone (639-3406) or e-mail us (ims@imsonline.org) if you need to verify Member names.

- 1. _____
- 2. _____

MEMBERSHIP DUES

(Please make check payable to Indianapolis Medical Society)

<i>MEMBERSHIP CATEGORY</i>	<i>IMS</i>	<i>ISMA</i>	<i>DISTRICT</i>	<i>AMA (Optional)</i>	<i>TOTAL (with AMA)</i>	<i>TOTAL (without AMA)</i>
<i>REGULAR</i>	\$325.00	\$385.00	\$10.00	\$420.00	\$1140.00	\$720.00
<i>1st YEAR PRACTICE</i>	\$162.50	\$193.00	\$10.00	\$210.00	\$ 575.50	\$365.50
<i>RESIDENT</i>	\$ 0.00	\$ 50.00	\$ 0.00	\$ 45.00	\$ 95.00	\$ 50.00
<i>AFFILIATE</i>	\$325.00	-0-	-0-	-0-	-0-	\$325.00

CHECKLIST: *(Please review before returning form.)*

- _____ 1. I have enclosed a **photo** for publication and for inclusion in my membership file.
- _____ 2. I have enclosed copies of my current **State Controlled Substances Registration and Federal DEA certificate**.
- _____ 3. I have enclosed a copy of my current **medical license**.
- _____ 4. I have enclosed a copy of my **board certification certificate**.
- _____ 5. I have **signed the application**.
- _____ 6. I have enclosed my **membership dues** (check made payable to Indianapolis Medical Society). *Payment can also be made by Visa or MasterCard.*

I hereby certify that I am a legally registered physician with an unrestricted license, residing or practicing in Marion County or an adjoining county, in the State of Indiana, and that I have not been convicted of a felony. If accepted as a member, I agree to abide by the Constitution and Bylaws of my county medical society and the Indiana State Medical Association, and the Principle of Medical Ethics of the American Medical Association.

Signature: _____ Date: _____

If you have any questions, please call Tyna McCauley at 639-3406.

Please return all items to:

INDIANAPOLIS MEDICAL SOCIETY

631 East New York Street
Indianapolis, IN 46202-3706

Telephone (317) 639-3406

E-mail: ims@imsonline.org

Fax (317) 262-5609