Application for Membership - Residents/Fellows

Please indicate the organizations for which you are making application:

____ **Oklahoma County Medical Society/Oklahoma State Medical Association**
____ **American Medical Association**
____ **I am currently a member of the AMA.**

Information should be typed or written legibly in ink.

____ ______________
Last Name **First Name** **Middle Name** **Suffix** **Professional Degree**

__________ __________________ ________________________________
Sex **Date of Birth** **Place of Birth**

__________________________ ________________ ________________________________
Social Security Number **Marital Status** **Spouse's Name (if applicable)**

Licensed in Oklahoma by: **Examination** ____ **Reciprocity** _____ **Oklahoma License #** ___________________ **Date** ________________

If by reciprocity, give state in which first license was issued ____ **Date** ________________

Office Address: ____ __________________ _________-_______
Street **City** **Zip Code**

Telephone: __________ ____________________ **Fax**: __________ ____________________
Area Code **Number** **Area Code** **Number**

Date you began practice in this location: __________________________

Residence Address: ____ __________________ _________-_______
Street **City** **Zip Code**

Telephone: __________ ____________________ **E-Mail Address**: ______________________________
Area Code **Number**

Preferred Method of Communication: **Home Mail** ______ **Office Mail** ______ **Fax** ______ **E-mail** ______

Foreign Languages Spoken (Include Sign Language): ____

____ **Fluently**: ___________ **Partially**: ____________

UNDERGRADUATE & MEDICAL EDUCATION

Undergraduate University: ____ **Degree**: __________________

____________________ ____________ ____________________ **Date**: _________ ________
City **State** **Country** **From** **To**

1. **Medical School:** ______________________________ **Degree**: __________________

____________________ ____________ ____________________ **Date**: _________ ________
City **State** **Country** **From** **To**

2. **Medical School**: ____ **Degree**: __________________

____________________ ____________ ____________________ **Date**: _________ ________
City **State** **Country** **From** **To**

ECFMG Number (if applicable): ____________________ ____________________ ____________________
Number **Date Granted** **Date Expires**

INTERNSHIP

Institution: ____

City	State	Country	Date: From	To

RESIDENCIES/FELLOWSHIPS/PRECEPTORSHIPS

1. Institution: ______________________________ **Specialty**: ______________

City	State	Country	Date: From	To

2. Institution: ______________________________ **Specialty**: ______________

City	State	Country	Date: From	To

3. Institution: ______________________________ **Specialty**: ______________

City	State	Country	Date: From	To

4. Institution: ______________________________ **Specialty**: ______________

City	State	Country	Date: From	To

ARMED SERVICES/PUBLIC HEALTH

____ ______________________

Branch (Army, Navy, Air Force, Marines, U.S. Public Health) **Dates of Active Service**

I, the undersigned applicant, hereby certify that I understand fully that membership in the Oklahoma County Medical Society, Oklahoma State Medical Association and American Medical Association is a privilege and not a right. If this application is approved and I am accorded the privilege of membership, I hereby agree to abide by the provisions of the OSMA and AMA Constitution and Bylaws and to practice in accordance with the established usages of the profession, and endorse the Principles of Medical Ethics set forth by the American Medical Association.

Date: ______________________ ______________________________

Signature of Applicant

Date: ______________________ ______________________________

Secretary – Oklahoma County Medical Society

Please return the completed application to: **Membership Coordinator, Oklahoma County Medical Society,**
313 NE 50th Street, Suite 2, Oklahoma City, OK 73105