



Type of Practice: Solo \_\_\_\_\_ Large Group (7+) \_\_\_\_\_ Partnership (1-2) \_\_\_\_\_ Small Group (3-6) \_\_\_\_\_  
 University \_\_\_\_\_ Not in Private Practice \_\_\_\_\_ Other \_\_\_\_\_

Foreign Languages Spoken (Include Sign Language): \_\_\_\_\_  
 \_\_\_\_\_ Fluently: \_\_\_\_\_ Partially: \_\_\_\_\_

**EDUCATION**

1. Undergraduate University: \_\_\_\_\_ Degree: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 City State Country From To
2. Medical School: \_\_\_\_\_ Degree: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 City State Country From To
3. Internship Institution: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 City State Country From To
4. Residency Institution: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 City State Country From To
5. Fellowship Institution: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 City State Country From To

**ARMED SERVICES/PUBLIC HEALTH**

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

Please list all professional fellowships, memberships and societies, including state and county medical societies.

Name of Organization	From	To
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 OCMS, 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: \_\_\_\_\_

Recommended by (two OCMS members): \_\_\_\_\_ Approved by the OCMS Board of Censors: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_ \_\_\_\_\_ Date: \_\_\_\_\_

Secretary - Oklahoma County Medical Society \_\_\_\_\_ Date: \_\_\_\_\_

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