



**Resident Physician Membership Application
Dade County Medical Association
Florida Medical Association**



Name: _____ MD/DO
(Please Print) (Circle One)

Address: _____

City/State/Zip: _____

Work Phone: _____ Home Phone: _____

E-mail Address: _____ Birthdate: _____

Medical Education # (if known): _____ Gender: _____

Hospital: _____

Specialty: _____

Post Graduate Year of Training: _____

Medical School: _____ Year of Graduation: _____

Residency Program Director or Department Chair:

Name: _____

Title: _____

Address: _____

City/State/Zip: _____

Office Phone: _____

Referred by: _____

NOW FREE MEMBERSHIP

**Dade County Medical Association
+ Florida Medical Association
Membership
FREE**

***There is no reason
not to join.***

**Political Action
Committee Membership**

**DCMA/FMA/AMA
\$25.00**

MEMBERSHIP QUALIFICATION QUESTIONS

Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign and date. **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 other 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 the 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 (ies).

The foregoing information is true and complete.

◆ 2 EASY WAYS TO PAY ◆

Cash or Check
Please make checks payable to:
**Dade County Medical Association
1501 NW North River Drive
Miami, FL 33125**

Signature _____ Date _____
10/26/06

