



IDAHO MEDICAL ASSOCIATION

P.O. Box 2668 * 305 W. Jefferson * Boise, Idaho 83701 * (208) 344-7888 * (208) 344-7903 * www.idmed.org

PHYSICIAN MEMBERSHIP APPLICATION

- GENERAL INFORMATION -

Name:		Degree:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Practice Name:		Office Phone:	
Primary Office Address:		Fax:	
Office Manager Name:		Telephone:	
Satellite Practice Name:		Sat. Phone:	
Satellite Office Address:		Sat. Fax:	
Home Address:		Home Phone/Fax:	
Date of Birth:	Spouse Name:	Spouse Physician: Yes <input type="checkbox"/> No <input type="checkbox"/>	
**Applicant E-mail:			
*Office Emergency Contact Name:		**Contact E-mail:	

- EDUCATION/PROFESSIONAL PRACTICE INFORMATION -

Medical Education:	Dates:
Internship:	Dates:
Residency:	Dates:
Fellowship:	Dates:
Idaho License (Number/ Issue Date):	
Board Certifications (Specialty(ies)/ Date):	Idaho Start Date:
Specialty(ies):	

- MEMBERSHIP QUALIFICATIONS -

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics of the American Medical Association and the Idaho Medical Association and to be governed by the Constitutions and By-Laws of the County Medical Society and the Idaho Medical Association.

** The emergency contact name is the person in your office that you rely on to receive important updates and notices that will need to be distributed to you and your office staff in a timely manner.*

***A majority of our members receive most IMA communications via e-mail, the method preferred by the IMA. Neither of these addresses will be listed in any IMA publications or released to any person or entity by the IMA.*

Applicant Name: _____ **Date:** _____

Applicant Signature: _____