



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 Address:		Sat. Fax:	
Home Address:		Home Phone/Fax:	
Date of Birth:	Spouse Name:	Spouse Physician: Yes <input type="checkbox"/> No <input type="checkbox"/>	
*Office Emergency Contact Name:		**Contact E-mail:	
**Applicant E-mail:			

- EDUCATION/PROFESSIONAL PRACTICE INFORMATION -

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

- ACMS ROSTER INFORMATION -

Accepting Medicaid: Yes <input type="checkbox"/> No <input type="checkbox"/>	Medicare: Yes <input type="checkbox"/> No <input type="checkbox"/>	Tricare: Yes <input type="checkbox"/> No <input type="checkbox"/>
Accepting New Patients: Yes <input type="checkbox"/> No <input type="checkbox"/>	Office Hours:	
HMO's Accepted:	Age of Patients:	
Private Insurances Accepted:	Payment Policy:	
Current Medical Association Affiliations:		
Local Hospital Privileges:		

- 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.

**The majority of our members receive most IMA communications via e-mail (the method preferred by the IMA). Neither of the above email addresses will be listed in any IMA publications or released to any person or entity by the IMA.

Applicant Name: _____ **Date:** _____

Applicant Signature: _____