# Arkansas Medical Society

## Membership Application

Post Office Box 55088 • Little Rock, Arkansas 72215 • 501-224-8967 • 800-542-1058 • (FAX) 501-224-6489
www.ArkMed.org • Facebook.com/ArkMedSoc • Twitter.com/ArkMedSoc • Instagram: @arkmedsociety

FULL Name: _____ (Last / First / Middle)

☐ Male ☐ Female ☐ MD ☐ DO

Birthdate _____ MO/DAY/YEAR

Primary Email: _____ Secondary Email: _____

**I prefer to be contacted at my:** ☐ Office ☐ Home **Best way to reach me:** ☐ Email ☐ Mail ☐ Fax

### OFFICE INFORMATION

Clinic Name _____

Address: _____ (Street) _____ (City/State/Zip)

Telephone: _____ Fax: _____

Clinic Manager: _____ Clinic Manager Email: _____

**Practice Environment:**

☐ Owner/part owner of physician-owned group ☐ Employed by a physician-owned group

☐ Employed by hospital/hospital system (non-academic) ☐ Employed by an academic institution ☐ Other

### HOME INFORMATION

Spouse's Name: _____ Address: _____ (Street / City/State/Zip)

Telephone: _____ Fax: _____

### PROFESSIONAL BACKGROUND

Ark Medical License: _____ (Number & Year issued) Specialty: _____ First Year of Medical Practice: _____

Practice Locations (city/state) 1. _____ from (year) _____ to _____

2. _____ from (year) _____ to _____

### MEDICAL EDUCATION

_____ (School) _____ (Year Graduated)

### INTERNSHIP/RESIDENCY

_____ (School) _____ (Year Completed)

_____ (City/state or country)

### COUNTY MEDICAL SOCIETY MEMBERSHIP

I would also like to join the _____ county medical society.

I hereby make application for membership in the Arkansas Medical Society, and, if accepted as a member, I agree to support its Constitution and By-Laws, to practice in accordance with the established usages of the profession, and to abide by the Principles of Medical Ethics as espoused by the American Medical Association.

_____ (Signature) _____ (Date)

### MEMBERSHIP DUES INFORMATION

☐ Active Member $400

☐ First year of Practice in Arkansas $100

☐ Check payable to Arkansas Medical Society

☐ Visa ☐ MasterCard

_____ Name on Card

_____ Billing Address (if different from above)

_____ City, State, Zip

_____ Credit Card Number

_____ Exp. Month/Year ___ ___ ___ Security Code

_____ Signature (Required)