LOUISIANA STATE MEDICAL SOCIETY

OUACHITA MEDICAL SOCIETY
Serving Northeast Louisiana

TO JOIN, MEMBERSHIP IS REQUIRED IN BOTH THE LSMS AND OUACHITA MEDICAL SOCIETY

PERSONAL AND PROFESSIONAL INFORMATION

Full Name: _____ Degree: ☐ MD ☐ DO LA License#: _____

Gender: ☐ Male ☐ Female Birth Date: _____

Home Address: _____

City: _____ State: LA Zip: _____ Spouse's Name: _____

Home Phone: _____ Cell Phone: _____

Home Email: _____ Primary Specialty: _____

Practice Name or Group: _____

Office Address: _____

City: _____ State: LA Zip: _____

Office Phone: _____ Office Fax: _____

Office Email: _____ Office Manager: _____

Medical School: _____ Year Degree Received: _____

Residency Program: _____ Year Completed: _____

Preferred Mailing Address: ☐ Home ☐ Work Preferred Email Address: ☐ Home ☐ Work

Members are governed by the Louisiana State Medical Society (LSMS) Principals of Medical Ethics and must comply with the bylaws of the LSMS and Parish Component Medical Society. To assist in upholding these standards, please provide answers to the following questions. 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 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 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.

The foregoing information is true and complete.

_____ _____

Signature Date

If membership has been recommended to you by a LSMS/OMS member, please list his/her name here: _____

TYPE OF MEMBERSHIP (CIRCLE ONE)

Practicing	$650	1st Year in Practice	$450	Part-time (20 hrs max/wk)	$450
Academic	$650	2nd Year in Practice	$550	Service (Military/VA)	$450

PAYMENT INFORMATION

☐ Charge my credit card: ☐ MC ☐ VISA ☐ DISC ☐ AMEX

Name on Card: _____

Card Billing Address: _____

Card Number: _____ Exp. Date: _____

Security Code: _____ 3 digits on back or AMEX 4 digits on front

Signature: _____

☐ Check enclosed (Payable to the LSMS)

TOTAL MEMBERSHIP DUES:

LSMS AND OUACHITA MEDICAL SOCIETY DUES: $ _____

Completed application and payment should be mailed to LSMS Membership Department, 6767 Perkins Road, Ste 100, Baton Rouge, LA, 70808. Please note: Additional information may be requested by Ouachita Medical Society to activate your membership. If you need additional information, please contact the LSMS Membership Department at 800-375-9508, 225-763-8500, or membership@lsms.org.