OUACHITA MEDICAL SOCIETY
P.O. Box 2884, Monroe, LA 71207
(318) 512-6932
director@ouachitams.org

Membership Application

Full Legal Name:_____

Name As You Would Like It Listed:_____

Degree: ○ MD ○ DO LA License #:_____

Undergrad School:_____ Location:_____ Year Degree Received:_____

Medical School:_____ Location:_____ Year Degree Received:_____

Residency:_____ Location:_____ Year Completed:_____

Fellowship (if applicable):_____ Location:_____ Year Completed:_____

PERSONAL INFORMATION

Gender: ○ Male ○ Female Date of Birth:_____

Home Address:_____

City:_____

State:_____ Zip:_____

Spouse's Name:_____

Home Phone:_____

Cell Phone:_____

Home Email:_____

PROFESSIONAL INFORMATION

Primary Specialty:_____

Secondary Specialty (if applicable):_____

Practice Name:_____

Office Address:_____

City:_____ State:_____ Zip:_____

Office Phone:_____ Office Fax:_____

Office Email:_____

Website:_____

Office Contact Name / Email:_____

TYPE OF MEMBERSHIP (select one)

○ Practicing $350 ○ Part-Time (20 hours max per week) $175 ○ Resident / Medical Student $0

PAYMENT (select one)

○ Check Enclosed (payable to OMS)

○ Credit Card One-Time Payment

○ Credit Card Auto Membership Renewal (*Schedule your payment to be automatically charged annually to your card.)*

** **For credit card payments, we will add a service fee (our cost) of 2.9% of the transaction amount.** **

Card#_____

Exp._____ / _____ Security Code_____ Cardholder Name_____

Billing Address_____ City_____ State_____ Zip_____

MAILING

Completed application and payment should be mailed to: Ouachita Medical Society • P.O. Box 2884 • Monroe, LA 71207

Continue to the back and complete form →

Members are governed by the Ouachita Medical Society (OMS) Principals of Medical Ethics and must comply with the bylaws of the OMS. 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?

○ Yes ○ No 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.

○ Yes ○ No 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:_____

REFERRAL

If membership was recommended to you by an OMS member, please list his/her name: _____