TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

Texas Medical Association
401 West 15th Street
Austin, TX 78701-1680

TMA/County Medical Society Membership Application

Membership Type: ☐ Resident ☐ First Year in Practice ☐ Active ☐ Military

BIOGRAPHICAL INFORMATION AND EDUCATION

Name: Last First Middle Suffix Degree Gender

☐ Office Address *(check if this is your preferred contact address)* City State ZIP

Work Phone Work Fax Work E-mail

☐ Home Address *(check if this is your preferred contact address)* City State ZIP

Home Phone Home Fax Home E-mail

Date of Birth Place of Birth (Country) Texas Medical License # NPI #

Marital Status Spouse's Name ☐ Yes ☐ No If married, is spouse also a physician?

Practice Name Specialty: Primary Secondary

Medical School Degree Grad. Date Residency/Fellowship (list most recent) Specialty Completion Date

PRACTICE TYPE AND EMPLOYMENT STATUS

☐ Direct Patient Care
☐ Direct Patient Care and Teaching
☐ Direct Patient Care and Research
☐ Administration (non-clinical)
☐ Full-Time Teaching (non-clinical)
☐ Research (non-clinical)
☐ Not in Patient Care
☐ Military
☐ Veterans Administration
☐ Not Employed
☐ Phys.-owned Prac.
☐ Direct Emp. by Hosp.
☐ Hospital NPHO
☐ Academic Inst.
☐ FQHC
☐ Retired
☐ Other

MEMBERSHIP QUALIFICATION AND AUTHORIZATION

	Yes	No
Have you ever had an application for membership in a medical society rejected?	☐	☐
Have you ever been convicted of a crime, other than a non-felony motor vehicle violation?	☐	☐
Has your medical license ever been revoked or suspended?	☐	☐
Have you ever been subjected to disciplinary action by any of the following?		
Board of Medical Examiners	☐	☐
County/State Medical Society	☐	☐
Hospital Medical Staff	☐	☐

I hereby apply for membership in the _____ County Medical Society and Texas Medical Association and, if accepted, agree to abide by and be subject to terms and conditions of the Constitution and Bylaws of the Society and of the TMA and the Principles of the Medical Ethics of the American Medical Association. In order to process my application for membership, I grant permission and consent for you to obtain from any appropriate source all relevant information concerning my credentials and qualifications.

I understand that if my application for membership is denied by the Board of Censors, I have a right to appeal the denial to the County Medical Society pursuant to the *Hearings Procedure Manual*. I also understand that if my application for membership is denied, based on professional competence or conduct, the County Medical Society must report such a professional review action to the National Practitioner Data Bank through the Texas Medical Board within 15 days of the date that all due process rights have been exhausted.

I also agree that biographical information will be disseminated in accordance with the policy and procedures established by the TMA Board of Trustees unless otherwise directed by me.

Physician Signature (required) _____ Date_____

APPROVAL OF BOARD CENSORS

The Board of Censors have had the above application under consideration, and: ☐ Approve *or* ☐ Disapprove on Date _____

Signature and Title

Note: Membership becomes effective when application has been approved and dues have been paid to the association.

PAYMENT INFORMATION

A physician becomes a member of the Texas Medical Association when joining the county medical society, since the county society is a component organization chartered by the association. $20 of TMA active membership dues is for a one-year subscription to *Texas Medicine*. **Dues paid to the county society and TMA are not deductible as charitable contributions for federal income tax purposes.** A portion of dues may be deductible as ordinary and necessary business expenses.

☐ Check (make payable to Texas Medical Association) ☐ Credit Card: ◯ VISA ◯ MasterCard ◯ Discover ◯ AMEX

☐ Automatic Dues Renewal: By checking "Automatic Dues Renewal," I authorize TMA to retain my credit card information securely and to charge my credit card to pay my membership dues annually.

Name as it appears on card_____Credit card number _____ Expiration date _____

Signature (required)_____

PLEASE SUBMIT PAYMENT WITH MEMBERSHIP APPLICATION TO:
Texas Medical Association, 401 W. 15th St., Austin, TX 78701-1680 Phone: (800) 880-1300 Fax: (512) 370-1631