TMA Tennessee Medical Association

Physicians Caring for Tennesseans

Membership Application

The Tennessee Medical Association is an organization for physicians licensed to practice medicine in Tennessee who care about the quality, enjoyment and profitability of their practices. Membership entitles you to resources to help you maximize the value of your practice, be a better advocate for patients and connect you with members statewide to strengthen the community of medicine.

This application is for membership in the Tennessee Medical Association and the

Local Medical Society:______________________________

County Where Your Primary Practice is Located

PERSONAL DATA

First:______________ Middle:______________ Last:______________

❑ MD ❑ DO

❑ Male ❑ Female Birth Date:______________ SS#:______________

TN Medical License #:______________ Date of Issue:______________

Marital Status: ❑ Single ❑ Married Maiden Name:______________

Spouse's Name:______________

ADDRESS/COMMUNICATIONS INFORMATION (Please check the preferred address for TMA correspondence)

❑ Primary Office Street/PO Box ______________

City/State/Zip ______________

❑ Home Street/PO Box ______________

City/State/Zip ______________

Practice/Group Name:______________

Email:______________ ❑ *Check here if you prefer e-mail communication*

Office Phone:______________

Office Fax:______________

Home Phone:______________

Consent to Fax: ❑ YES ❑ NO

I understand that by providing my fax number and/or e-mail address and checking "yes" above, I consent to receive faxes and/or e-mails sent by the Tennessee Medical Association or on behalf of its chartered component medical societies.

MEDICAL TRAINING

Specialty:______________ Subspecialty:______________

Board Certification(s):______________

Boards and Dates

❑ Residency

❑ Fellowship______________

Name of Institution, Location, Specialty, Degree

❑ Residency

❑ Fellowship______________

Name of Institution, Location, Specialty, Degree

Medical School ______________

Name of Institution, Location, Graduation Date, Degree

MISCELLANEOUS

Please provide complete information on a separate sheet to explain 'yes' answers below:

Has your license to practice medicine in any jurisdiction been limited, suspended or revoked? ❑ Yes ❑ No

Have you ever been the subject of any disciplinary action by any medical society or hospital staff? ❑ Yes ❑ No

Have you ever been convicted of a felony? ❑ Yes ❑ No

AGREEMENT

In signing this application, I agree that all statements are true and complete to the best of my knowledge and belief. If accepted as a member, I agree to conduct myself professionally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the component medical society, the Tennessee Medical Association and the American Medical Association. I hereby release and hold harmless from any liability or loss the component medical society to which I am applying, the Tennessee Medical Association, its officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications and hereby release from any liability any and all individuals who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership.

____ ____________________

Signature of Applicant Date

Physician who asked you to join:______________________________________

Annual Dues Submission

Please remit your completed application along with a check or credit card information to:

Tennessee Medical Association Membership
P O Box 120909
Nashville TN 37212-0909

Payment Information

Please check one: ❑ Visa ❑ MasterCard ❑ American Express

Total $________________ Expiration Date_______/_______ 3 Digit Security Code________

CC# ____________-____________-____________-____________

❑ Personal ____

Name as it appears on credit card

❑ Corporate* ____

**If corporate, name of corporation*

Please Fax to 615-312-1960

FOR TMA USE ONLY - MEDICAL SOCIETY APPROVAL

❑ Active, Full-time Practice
❑ First Year of Practice Following Training
❑ Second Year Of Practice Following Training
❑ Resident
❑ Student

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Signature for CMS Approval *Date*