



2011 MEMBERSHIP APPLICATION

Harris County Medical Society & Texas Medical Association Membership

BIOGRAPHICAL DATA						
Name:	Last	First	Middle	Suffix	Degree	Gender
Office Address			City	State		Zip
Phone		Fax		Email		
Date of Birth	Texas Medical License #			Specialty		

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Has your medical license ever been revoked or suspended?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

SIGNATURE & AUTHORIZATION
<p>I hereby apply for membership in the Harris County Medical Society and Texas Medical Association and, if accepted, agree to abide by the subject terms and conditions of the Constitution and Bylaws of the Society and the Texas Medical Association and the Principles of the Medical Ethics of the American Medical Association.</p> <p>In consideration of the Harris County Medical Society processing 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 further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character, and ethical qualification to all hospitals, medical discipline boards, and medical licensure boards which request such information. I also agree that the biographical information will be dismissed in accordance with the policy and procedures established by the TMA Council on Communication unless otherwise directed by me.</p>
Signature (required) _____ Date _____

PAYMENT INFORMATION
<p>A portion of your dues may be tax deductible as ordinary and necessary business expenses. It is estimated that 16% of your 2011 TMA dues are nondeductible, as that portion is allocable to lobbying as defined by law. \$15 of your Harris County Medical Society and Houston Academy of Medicine dues is allocated to the Harris County Physician Newsletter subscription. \$20 of your Texas Medical Association annual dues are allocated to the Texas Medicine subscription. For tax purposes the portion of your dues allocable to HCMS and TMA are: HCMS: \$200.00, HAM \$35.00, TMA \$501.00, Total = \$736</p> <p>To Pay by Credit Card: Please Circle one: MasterCard / Visa / Discover / AMEX <i>First year in practice rate is \$368 – first year after residency/fellowship</i></p>
Credit Card No. _____ Exp. Date: _____ Name as appears on credit card: _____
Billing Address: _____ Billing City, State & Zip: _____
Signature: _____ Total Amount Charged: _____
Or Mail Payment to: Harris County Medical Society, 1515 Hermann Drive, Houston, TX 77004-7126
<i>All credit card information is privileged and confidential and will not be duplicated or distributed in any way. If you have any questions, please contact the Membership Office at 713-942-7059. You may fax your payment information to 713-526-1434.</i>

We, the Board of Ethics, Approve Disapprove this application. Chair Signature _____ Date _____

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