



# 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Has your medical license ever been revoked or suspended?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> <p>Signature (required) _____ Date _____</p>

PAYMENT INFORMATION	
<p><b>2011 Membership Dues:</b></p> <ul style="list-style-type: none"> <li>• <b>Regular Dues: \$368</b> (Distributed as follows: Texas Medical Association \$250.50; Harris County Medical Society \$100.00; Houston Academy of Medicine \$17.50)</li> <li>• <b>First Year In Practice Dues: \$184</b> (first year after completing your residency/fellowship program) (Distributed as follows: Texas Medical Association \$125.25; Harris County Medical Society \$50.00; Houston Academy of Medicine \$8.75)</li> </ul> <p><b>To Pay by Credit Card:</b></p> <ul style="list-style-type: none"> <li>• Fill out credit card information below and fax it to <b>713-526-1434</b>.</li> <li>• Please Circle the type of Credit Card:                      MasterCard / Visa / Discover / American Express</li> </ul> <p>Credit Card No. _____ Exp. Date: _____ Name as appears on credit card: _____</p> <p>Signature: _____ Total Amount Charged: _____</p> <p><b>To Pay by Check:</b></p> <ul style="list-style-type: none"> <li>• Please make one check payable to the <b>Harris County Medical Society</b> and mail to 1515 Hermann Drive, Houston, TX, 77004.</li> </ul> <p><i>All credit card information is privileged and confidential and will not be duplicated or distributed in any way.</i></p>	<p style="text-align: center;"><i><b>If you have any questions, please contact the HCMS Membership Office at 713-942-7059.</b></i></p> <p style="font-size: small;">A portion of your dues may be tax deductible as ordinary and necessary business expenses. It is estimated that 18% 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.</p>

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.**