Application for Membership

The Academy of Medicine of Toledo & Lucas County

Place Photo Here

or email to joey.begeman @gmail.com

Membership Category:

___ Active, Full-Time
___ Part-Time (<20 hrs./week)

INTERNAL USE ONLY
Med. Ed. #_____

(Please print or type)

First Name | Middle | Last Name | MD/DO

Date of Birth | Birthplace | Naturalization Date/Loc. (if applicable)

Practice/Group Name

Primary Office Address | City | State | ZIP Code

Primary Office Telephone | Office Fax | Office E-Mail

Home Address | City | State | ZIP Code

Home Telephone | Home Fax | Home E-Mail

Preferred Mailing Location: ☐ Office ☐ Home Gender: ☐ Male ☐ Female

Spouse Name

Medical Licensure (please include copy of wallet-sized license with application)

Ohio License No. | Expiration Date

Have you been or are you currently licensed in another state/province? If yes, please provide locations, numbers and dates.

State/Province | License No. | State/Province | License No. | State/Province | License No.

Medical Education

Medical School | City | State | Graduation Date

Internship - Institution | City | State | Dates | Specialty

Residency - Institution | City | State | Dates | Specialty

Residency - Institution | City | State | Dates | Specialty

Fellowship - Institution | City | State | Dates | Specialty

Primary Practice Specialty | Board Certification

Secondary Practice Specialty | Board Certification

Date entered active practice: _____-_____-_____

Past County/State Medical Society Membership(s)

Current Hospital Appointments (names, location, dates)

Previous Hospital Appointments (names, locations, dates)

Has your license to practice medicine in any jurisdiction ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a licensing agency; or have you ever surrendered your license?

_____ No _____ Yes. If yes, please explain _____

Have you ever been convicted of a felony or are you presentjy under indictment?

_____ No _____ Yes. If yes, please explain _____

Please initial the line next to each statement to confirm agreement and sign below.

_____ I hereby certify that I am a legally registered physician, residing or practicing in the County of _____ in the State of _____ and that I have not been convicted of a felony. If accepted as a member, I agree to abide by the Constitution and Bylaws of The Academy of Medicine of Toledo and Lucas County.

_____ I understand that conviction of fraud or a felony, or actions involving revocations, suspension, limitation, probation, or any other sanctions or conditions imposed upon a license to practice or disciplinary action by any other medical society or hospital staff, after due notice and hearing, may result in censure, suspension or expulsion of a member. The Health Care Quality Improvement Act requires professional societies to report certain professional review actions that adversely affect membership, including denial of membership, to the National Practitioner Data Bank.

_____ I understand that additional information may be requested by the county medical society in order to complete the application process.

Signature _____ **Date** _____

Please include the following with your application:

- ☐ **Copy of your Ohio Medical License**
- ☐ **Current Curriculum Vitae**
- ☐ **Photo (or email digital image to joey.begeman@gmail.com)**
- ☐ **Copy of any Board Certifications**

FOR OFFICE USE ONLY. Please DO NOT write below this line. Academy of Medicine Approval:

Name _____ Office/Title _____

Date received by The Academy ___-___-_____ Type of Membership _____

Date of first reading by Council ___-___-_____ Date action taken by Judicial & Internal Affairs Commission ___-___-____

Recommendation _____

Approved_____ _____

_____ _____

_____ _____

Action of Council _____

President_____ Date _____

Election to Fellowship: Action of Council _____

President_____ Date _____