APPLICATION FOR ACTIVE MEMBERSHIP

OHIO DERMATOLOGICAL ASSOCIATION
698 Dalton Fox Lake Road Dalton, Ohio 44618
330.465.8281 Fax: 330.985.0036

Please send application along with $250 membership dues to the above address

PLEASE PRINT

Full Name _____
First MI Last MD/DO

Date of Birth:_____

Office Information:

Company Name_____

Office Address:_____

_____

Office Phone:_____

Office Fax:_____

Office Website:_____

County:_____

Practice Associates:_____

Home Information:

Home Address:_____

_____

Home Phone:_____

Cell Phone:_____

E-mail: _____

Preferred Mailing Address: □ Office □ Residence

Education Information:

Medical School_____Degree_____Year_____

Year Licensed in Ohio_____ Ohio Medical License Number _____

Licenses in Other States_____

Residency_____
Institution Dates Type

Dermatology Residency Training_____
Institution Dates

Fellowship_____
Institution Dates Specialty

Additional Information:

Board Certified in Dermatology? □ Yes □ No
If Yes: □ American Board of Dermatology □ Osteopathic Year_____

Member, American Academy of Dermatology: □ Yes □ No
Classification_____Year_____

American Osteopathic College of Dermatology:
Classification_____Date_____

Medical Education Number:_____

Society Memberships (list):_____

_____

University Appointment:_____

Local Hospital Staff Memberships:_____

_____

Former Hospital Staff Memberships:_____

_____

Former Place(s) of practice with dates:_____

_____

Formerly a member of a county medical society?_____
City State

Have you previously been a member of the ODA? □ Yes (Year_____) □ No
If yes, reason for not maintaining membership:

_____

Are there any current or pending restrictions on any medical license? □Yes □No
If yes, attach explanation.

PLEASE READ CAREFULLY AND COMPLETE THE FOLLOWING

I hereby release from liability all representatives of the Ohio Dermatological Association for their acts performed in good faith, without malice and in reasonable belief that any information gathered or exchanged is warranted by the facts known to them.

I understand and agree that this release and consent is irrevocable. I understand and agree that I, as an applicant for membership, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications for membership.

I agree to return my certificate of membership if my license to practice medicine "in any state" is revoked, suspended, or limited beyond its present state, or if my membership is revoked for such other causes as may be placed legally in the bylaws of the Association.

I acknowledge responsibility for my membership dues.

Signature_____ Date_____