# Jefferson Parish Medical Society

*Physicians Committed to Quality in Medical Care*

## Membership Application

### PERSONAL INFORMATION

Last Name (as shown on medical license) _____ First Name _____ MI ____ Degree MD/DO _____ Birthplace _____ Date of Birth mm / dd / yy ____/____/____ Gender ____

Home Address _____ City _____ State _____ Zip _____

Telephone (____)_____ Fax (____)_____ E-mail Address _____ Marital Status _____ Spouse's Name _____

### PROFESSIONAL PRACTICE INFORMATION (IF APPLICABLE)

Louisiana License Number _____ Other State Licenses _____ ME # (if known-optional) _____ Preferred Mailing Address ☐ Office ☐ Home

Practice Name or Group (If Applicable) _____ Primary Specialty ____ _____ Subspecialty _____

Primary Practice Address _____ City _____ State _____ Zip _____

Telephone (____)_____ Fax (____)_____ E-mail Address _____ Website _____

### EDUCATIONAL INFORMATION

| | | | From | To |
|---|---|---|---|---|
| Undergraduate College | Degree | Address, City, State, Zip | Month/Year | Month/Year |
| Medical School | | Address, City, State, Zip | Month/Year | Month/Year |
| Internship (Hospital) | Specialty | Address, City, State, Zip | Month/Year | Month/Year |
| Residency (Hospital) | Specialty | Address, City, State, Zip | Month/Year | Month/Year |
| Fellowship | Specialty | Address, City, State, Zip | Month/Year | Month/Year |

### MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

Members abide by the bylaws of the Jefferson Parish Medical Society. To assist us in upholding these standards, please provide answers to the following questions, sign and date.
If you answer yes to any of these questions, please attach full information.

| Yes | No | |
|---|---|---|
| ❑ | ❑ | Have you ever been convicted of fraud or a felony? |
| ❑ | ❑ | Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any imposed sanctions or conditions. |
| ❑ | ❑ | Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff? |

I am aware that information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information. I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society.
The foregoing information is true and complete.

Signature _____ Date _____

### INVOICE

❑ **Total $250.00**

Please return with payment to:

**Jefferson Parish Medical Society**
**4937 Hearst Street, Suite 2B**
**Metairie, LA 70001**

**(504)455-8282 email@jpms.org**

**Method of Payment**:

❑ **Check** (Made payable to Jefferson Parish Medical Society)
❑ **Credit Card** ▫ Master Card ▫ Visa

|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Expiration Date: ____/____/____ (Required) mm /dd /yy _____ Security Code

Signature: _____