MONTANA MEDICAL ASSOCIATION

Membership Application

Also available online at www.mmaoffice.org

The MMA's mission is to serve our members as an advocate for the medical profession, quality patient care, and the health of all Montana Citizens.

Instructions:
Please complete and sign this application form to apply for membership in the Montana Medical Association.
Note in appropriate section if applying for membership in a geographical medical society.

APPLICANT INFORMATION

Name_____
Last First Middle

Business Address_____
Street or P.O. Box # City, State, Zip

Telephone (_____)_____(_____)_____ (_____)_____
Business Home Fax

Email_____ Date of Birth _____
mm/dd/yy

Home Address_____
Street or P.O. Box # City, State, Zip

EDUCATION & CERTIFICATIONS

Pre-Medical School_____
Degree Year

Medical School _____
Degree Year

Board Certifications:

Specialty	Name of Certifying Board	Date Certified mm/yy	Year Certification Expires mm/yy

LICENSE INFORMATION

*Montana License No._____ Date Issued:_____

Have you ever had your license revoked or suspended? ☐ Yes ☐ No
If yes, where and when?_____
_____

Complete back portion →

MEDICAL SOCIETY MEMBERSHIP(S)

If not a member of a geographical medical society, do you want to apply for membership through this application form? ☐Yes ☐No

Geographic Medical Society: _____

Do you currently belong to a State and/or National Medical Society? (Attach additional sheets as necessary)

State and/or National Medical Society	Last Year Dues Paid

PRACTICE INFORMATION

Start date of practice in Montana _____
List all locations of practice in Montana _____

Practice Environment: (Please check all that apply)

☐ Office/Clinic - Solo Practice
☐ Office/Clinic - Partnership
☐ Office/Clinic - Single Specialty Group
☐ Office/Clinic – Multi-Specialty Group
☐ Hospital - *Name* _____
☐ VA/Indian Health Hospital
☐ Federal/State/Community Health Center(s)
☐ Local Health Department
☐ Telemedicine
☐ Volunteer in a Free Clinic
☐ Work as locum tenens
☐ Other (specify): _____
☐ Retired/Date _____

Please indicate the percentage of time per week anticipated to be spent on providing direct clinical or patient care on a regular basis._____

OTHER INFORMATION

Military Service _____Active _____Retired _____N/A

Marital Status_____ Spouse's Name_____

Have you ever been convicted of a felony? ☐Yes ☐No
If yes, where and when?_____
_____

Have you ever had disciplinary action taken against you by a hospital or a medical society? ☐Yes ☐No
If yes, where and when?_____
_____

If elected to membership, I agree to conduct myself professionally and personally according to the "Principles of Medical Ethics" and to be governed by the Articles of Incorporations and By-Laws of the Montana Medical Association.

I hereby release, and hold harmless from any liability or loss, the above- named Medical Society, the Montana Medical Association, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above-named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

_____ _____
Applicant Signature Date

Send completed and signed applications to:
MMA Executive Office, 2021 11th Avenue, Suite 1, Helena, MT 59601-4890
mma@mmaoffice.org ~ Fax: (406) 443-4042