USF INTERN/RESIDENT/FELLOW MEMBERSHIP APPLICATION
HILLSBOROUGH COUNTY MEDICAL ASSOCIATION, INC. (HCMA)

Fax to: HCMA, 813/253-3737, or mail: HCMA, 606 S. Boulevard, Tampa, FL 33606

Print full name: _____MD/DO
(Circle one)

Circle one: INTERN RESIDENT FELLOW

Mailing Address: _____

Apt#: _____ City, _____ State, _____ Zip, _____

Phone #: _____ Mobile #: _____

E-mail: _____

(*Email address is required*)

Sex: _____ Birth date: _____ Birth place: _____

Spouse's Name: _____

Foreign Language/s you speak: _____

PRIMARY SPECIALTY: _____ #2 SPEC: _____

Med. School: _____

City, State: _____

Year of Graduation: _____

Internship location: _____

City, State: _____ Specialty: _____

Start date: _____ (Anticipated) Date of completion: _____

Residency location: _____

City, State: _____ Specialty: _____

Start date: _____ (Anticipated) Date of completion: _____

Fellowship location: _____

City, State: _____ Specialty: _____

Start date: _____ (Anticipated) Date of completion: _____

Name of person who recruited you (if applicable): _____

(Must complete application in full)

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By my signature, I agree to accept and be bound by the Articles of Incorporation and Bylaws of the HCMA, and the Principles of Medical Ethics of the AMA, together with all future amendments of such Articles of Incorporation, Bylaws, or Principles of Medical Ethics, which may be duly adopted by the respective organizations.

I, hereby release, and hold harmless from any liability or loss, the HCMA, 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. I understand that any false or misleading statements made on my application may be grounds for denial of membership or probation or censure by, or suspension of expulsion from, the HCMA.

I hereby certify that the foregoing is true and correct to the best of my knowledge. I understand and agree that if I knowingly make a false representation on this application or a representation that in the exercise of reasonable care I should have known to be false, the HCMA has the authority to reject this application.

Printed Name: _____ Date: _____

Signature: _____

Intern/Resident/Fellow Member Dues
***N/A**

Optional but Strongly Recommended
(circle additional dues and add to your total)

HCMA & FMA Alliance (Spouses)	$ 85
HCMA Foundation	$100
HILLPAC	$ 75

***As of September 2015, the HCMA Board of Trustees has waived dues for all USF Intern/Resident/Fellow Members**

Total Remitted: $_____Check #:_____

Make check payable to "HCMA" and mail to: HCMA, 606 S. Boulevard, Tampa, FL 33606

(You can reach the HCMA Headquarters at 813/253-0471)