MEMBERSHIP APPLICATION FOR THE
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

Office Address:

_____

Suite #: _____

City, Zip: _____

Phone #: _____

Private #: _____

Fax #: _____

E-mail: _____
(Email address is required)

Home Address:

_____

Apt #: _____

City, Zip: _____

Phone #: _____

Mobile #: _____

Fax #: _____

Spouse's Name: _____

(Please list additional addresses on a separate sheet of paper and circle the address you wish your mail be sent)

Sex: _____ Birth date: _____ Birth place: _____

Foreign Language/s you speak: _____

FL Medical License #: _____ USF Faculty: ☐

PRIMARY SPECIALTY: _____ #2 SPEC _____

(Each member is listed once, by primary specialty, in the HCMA Membership Directory)

Practice Name: _____

Practice Manager: _____ Practice Manager's phone #: _____

Practice Manager's email: _____

Education:

Med. School: _____ City, State: _____

Year of Graduation: _____

Internship location/Spec: _____City, State: _____ Dates: _____

Residency location/Spec: _____ City, State: _____ Dates: _____

Fellowship location/Spec: _____ City, State: _____ Dates: _____

Board Certification/s: _____ Year/s: _____

HCMA MEMBERSHIP APPLICATION (Page 2)

Name of person who recruited you: _____

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: _____

Active Member Dues		**Optional but Strongly Recommended**	
NEW & REINSTATED MEMBERS		**(circle additional dues and add to your total)**	
HCMA	~~$370~~ $250	HCMA & FMA Alliance (Spouses)	$ 85
*Processing Fee	$100	HCMA Foundation	$100
		HILLPAC	$ 75
Total:	**~~$470~~ $350**		

Total Remitted: $ _____ Check #:_____
Make check payable to "HCMA" and mail to: HCMA, 606 S. Boulevard, Tampa, FL 33606

*Processing Fee - is used for maintenance of the HCMA building and for necessary projects as approved by the HCMA Board of Trustees.

CREDIT CARD PAYMENT (circle one): Master Card VISA AMEX EXP DATE: _____

CARD #_____

Authorized Signature: _____

HCMA Members are now offered the option of automatic renewal. By signing below you will authorize the Hillsborough County Medical Association to automatically charge the above credit card to renew your dues at the current dues rate, in September of each year. To participate in this program, please sign below:

X_____ Printed name: _____

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

6/29/15