



**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

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**Print full name:** \_\_\_\_\_ MD / DO

**Mailing Address:**

\_\_\_\_\_

Apt# \_\_\_\_\_ City, \_\_\_\_\_ State, \_\_\_\_\_ Zip, \_\_\_\_\_

Phone # \_\_\_\_\_ Mobile # \_\_\_\_\_

E-mail: \_\_\_\_\_

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/Spec: \_\_\_\_\_

City, State \_\_\_\_\_ Dates: \_\_\_\_\_

Residency location/Spec: \_\_\_\_\_

City, State \_\_\_\_\_ Dates: \_\_\_\_\_

Fellowship location/Spec: \_\_\_\_\_

City, State \_\_\_\_\_ Dates: \_\_\_\_\_

Board Certification/s: \_\_\_\_\_ Year/s: \_\_\_\_\_

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**HCMA MEMBERSHIP APPLICATION**

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 ground 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 in 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: \_\_\_\_\_

<u>Intern/Resident/Fellow Member Dues</u>	<u>Strongly Recommended</u>
HCMA Pre-pay (up to 4 yrs) \$25.00	(circle additional dues and add to your total)
	HCMA & FMA Alliance (Spouses) \$ 85
	HCMA Foundation \$100
	HILLPAC \$ 50
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)