



HOMŒOPATHIC MEDICAL SOCIETY
of the
STATE of NEW YORK

Established 1862

A p p l i c a t i o n F o r M e m b e r s h i p

Date: _____

Name: _____

Office Address _____

Street

City *State* *Zip Code* *Office Phone*

E-mail address *Website* *Office fax*

Home Address _____

Street

City *State* *Zip Code* *Home Phone*

Degrees _____

New York License # _____

In what other states are you licensed to practice? _____

Homeopathic Interests _____

Special Interests _____

Type of Practice: DP Direct Patient Care AD Administration

RS Research

Class of Membership Desired and Annual Fees:

- Active Member includes MD's DO's. \$100 Annually Honorary
- Medical Student, Intern, Resident (submit copy of student ID or letter from program director). \$35 Annually

If you seek Active Membership, please complete this application. If you are applying for Student, Intern, or Resident Membership, STOP here and sign the application on page 4.

Applicants for Active Membership must include a copy of their New York State License with this application.

Date and place of Birth: _____ Citizenship _____

If naturalized, give date and certificate number: _____

EDUCATION: Undergraduate _____
College of University Degree Year
Medical School _____
Name Year Graduated

GRADUATE TRAINING (Give inclusive dates, months and year):

Internship _____
Hospital Type of Service Dates of Service
Residencies _____
Hospital Type of Service Dates of Service
Residencies _____
Hospital Type of Service Dates of Service
Fellowships _____
Hospital Type of Service Dates of Service

Homeopathic Education: _____

Training in your specialty if not included above (where obtained and dates): _____

PRACTICE:

- a. Exclusive of hospital and/or other training, for what period of time have you been engaged in practice? _____
- b. If a specialist, how long have you practiced your specialty? _____
- c. How long have you practiced in your present location? _____
- d. Have you practiced elsewhere? If so, give locations and dates: _____

TYPE OF PRACTICE:

- a. Independent
- b. Group
- c. Research
- d. Teaching
- e. Administrative
- f. Government
- g. Other (please specify) _____

CERTIFICATION: _____
Specialty Board(s) Date(s) of Certification

If not board certified, are you eligible for board certification? _____

HOSPITAL STAFF APPOINTMENTS:

Courtesy: _____

Attending: _____

TEACHING APPOINTMENTS: (Give title and school with dates)

PROFESSIONAL SOCIETIES:

Have you been or are you a member of any of the following (If so, please give name, dates, and class of membership where appropriate):

Local medical society _____

State or country medical society _____

Professional societies (specialty or others) _____

Diplomate, American Board of _____

American College of Physicians _____ Surgeons _____

American College of _____

Associate _____
Date

Fellow _____
Date

Elected Positions in Medical Societies _____

Have you ever been denied licensure in any state? No Yes

If yes, explain fully, and give current status of license involved.

Have you ever had your license revoked? No Yes

Are you currently or have you ever been investigated by the OPMC? No Yes

If yes, explain fully, and give current status of license involved.

Are you engaged in any governmental position, business, trade, or profession other than the practice of medicine?

No Yes If yes, please specify _____

Clubs of which you are a member other than professional _____

Publications (Give title, journal, volume, year, page, other authors). Please use separate sheet if necessary.

List 2 professional references, with full names and complete addresses. (One reference may be from a HMSSNY member.)

_____ In what capacity known? _____

_____ _____

_____ How long? _____

_____ In what capacity known? _____

_____ _____

_____ How long? _____

I request membership in the Homeopathic Medical Society of the State of New York. I have added or intend to add to my knowledge of medicine a knowledge of homeopathic therapeutics and observe the "law" or "principle" of similars. I share the concern for the advancement of homeopathic therapeutics and of all other departments of medicine and surgery.

To the best of my knowledge, I have answered the above questions fully and honestly. I agree to abide by the bylaws of the Homeopathic Medical Society of the State of New York, to pay all dues, fees, and assessments in a timely fashion, and to conduct my practice in an ethical manner.

Date _____ Signature _____

Please include a copy of a recent curriculum vitae and make check payable to HMSSNY for 1st year of membership dues.

APPLICANT MUST NOT WRITE BELOW THIS LINE

Received by HMSNY _____ References Received _____

Published to Membership _____

Membership effective _____ Class of Membership _____

Remarks: _____

Please return this form to:
HMSSNY Division of Membership