



ACADEMY OF MEDICINE OF CINCINNATI

7265 Kenwood Road • Suite 315 • Cincinnati, OH 45236-4411
513-421-7010 • Fax 513-721-4378 • www.academyofmedicine.org

MEMBERSHIP DUES INFORMATION/APPLICATION

Academy of Medicine of Cincinnati Membership Categories

Please check appropriate membership category, select a payment option, and complete application on reverse side.

ACTIVE: Any physician who has a current MD/DO license to practice issued by the State Medical Board of Ohio.

Previous Member — Physicians who held previous Active membership in the Academy. [\$399.00]

New/First Year Member — Physicians with no prior Academy Active membership history. [\$199.00]

Part-Time Member — Physicians with a current MD/DO license to practice issued by the State Medical Board of Ohio and practicing less than twenty (20) hours per week. [\$199.00]

NON-RESIDENT: Any physician holding a current license to practice medicine, who conducts the major portion of his or her practice outside of Hamilton County, Ohio. [\$195.00]

POST-GRADUATE TRAINEE: Any physician who has a current certificate or license issued by the State Medical Board of Ohio and is enrolled in an approved internship, residency, or fellowship program.
[First year, complimentary; subsequent years, \$30.00]

ASSOCIATE: Allied health practitioners holding a current license to practice in Ohio. [\$195.00]
[60% discount for Associate members who are supervised by an Active Academy member, *pay only \$78.00*]

AFFILIATE: Individuals interested in the work of the Academy who are not eligible for other Academy membership. [\$75.00]

HEALTH CARE ADMINISTRATOR: Any individual holding an executive/management position in a hospital or other health care facility. [\$150.00]

STUDENT: Any person who is enrolled in an approved college of medicine pursuing the degree of MD/DO.
[Complimentary]

Payment Options

Check enclosed (make checks payable to the Academy of Medicine of Cincinnati) Send Invoice

Charge to VISA MasterCard American Express Discover

Account # _____ Expiration Date _____

Name on credit card _____ Amount charged \$ _____

Cardholder Address _____

Cardholder's Signature _____ Phone _____

Payment arrangements are available and can be made by calling the Membership Department at 513-421-7010.

*If paying by check, return the completed application and check by mail to Academy of Medicine Membership Department,
7265 Kenwood Road, Suite 315, Cincinnati, OH 45236-4411.*

If paying by credit card, you may return the application by mail or fax to 513-721-4378.



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MEMBERSHIP APPLICATION

(Please print or type. Complete items applicable to your membership category.)

First Name Middle Last Name MD/DO/Other

Male Female

Date of Birth Medical School Graduation Date (actual or expected)

Home Address City State Zip Code

Home/Cell Phone Preferred Email Address

Active/Non-Resident/Associate/Health Care Administrator Members

Independent Employed

Practice/Group Name Web Address

Primary Office Address City State Zip Code

Primary Office Telephone Office Fax

Primary Specialty Board Certification Secondary Specialty Board Certification

Preferred Mailing/Billing Location: Office Home

Post-graduate Trainee Members

I am a Resident Fellow. I anticipate entering practice in the year _____.

Training Facility Dates Specialty

All Membership Categories

If accepted as a member, I agree to abide by the Academy of Medicine of Cincinnati Articles of Incorporation and Code of Regulations. I understand and agree that by providing my address, email(s), telephone numbers(s), and fax number(s), I consent to receive communications sent by or on behalf of the Academy of Medicine of Cincinnati via regular mail, email, telephone, or fax. By signing, I agree to the terms and conditions listed here.

Signature: _____ Date: _____

• Please complete both sides of the application. Questions, call 513-421-7010. •

Internal Use Only – Academy of Medicine of Cincinnati Approval

Name _____ Title _____
Please Print

Signature _____ Date _____