



Pennsylvania  
MEDICAL SOCIETY®

*Doctors and Patients. Preserve the Relationship.®*

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# Application for Practice Administrator

A practice administrator is one who directly manages a medical practice and is not a consultant. He or she is employed directly by a physician, or the physician and practice administrator are employed by the same organization.

**A practice administrator is not eligible for membership unless at least one physician in the practice is a member of the Pennsylvania Medical Society.**

County Medical Society \_\_\_\_\_

## Personal Information (please print)

Name \_\_\_\_\_ Sex:  Male  Female  
Last First Middle

Practice Name \_\_\_\_\_  
(Official name)

Office Address \_\_\_\_\_  
Street City State Zip

Phone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Practice Speciality \_\_\_\_\_

## Practice Information (You *must* attach a current roster of the physicians in your practice.)

Number of physicians (must be MDs or DOs) in your practice \_\_\_\_\_

Does your practice pay Pennsylvania Medical Society Membership dues for your physicians?  Yes  No

Would you like all your practice's dues invoices sent directly to the practice administrator?  Yes  No

Is the practice part of a parent organization or university?  Yes  No Please Name \_\_\_\_\_

Address of parent organization \_\_\_\_\_

Name of practice administrator (COO), if other than you \_\_\_\_\_

Within the last 5 years, have you been convicted of a felony crime?  Yes  No If yes, please provide full information.

If elected to administrate membership, I agree to conduct myself in a professional manner and to be governed by the Bylaws of the \_\_\_\_\_ County Medical Society, the Pennsylvania Medical Society, and the American Medical Association.

I hereby release, and hold harmless from any liability or loss, the \_\_\_\_\_ County Medical Society, and Pennsylvania Medical Society, 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 also authorize the above named organization, in the consideration of my application, to make inquiry of any of my references and institutions by whom I have been employed or extended privileges, as to my qualifications. I further authorize any of the above persons or institutions to forward any and all information their records may contain, and agree to hold them harmless for any action by me for their acts.

Date \_\_\_\_\_ Signature \_\_\_\_\_

### Did you remember to:

- Attach a roster or list of all physicians in your practice?
- Indicate both county and specialty?

Code: \_\_\_\_\_  
 (for internal use only)