MEMBERSHIP APPLICATION

ILLINOIS HOMEOPATHIC MEDICAL ASSOCIATION
400 East 22nd Street Suite F
Lombard, IL 60148
630.792.9311

Name: _____ Degree _____
(last) (first) (initial/middle)

Board Certified? _____ _____
(Board/Date Certified)

Birth Date: _____

_____
(Birthplace) (Citizenship ((country)) (Languages spoken other than English)

Homeopathic Board Certifications (e.g. DHt/DNBHE): _____

Other degrees held: _____

Specialties (list each specialty you currently employ and number of years practiced for each):

_____
Specialty 1 (years practiced) Specialty 2 (years practiced) Specialty 3 (years practiced)

Type of Practice (check as many as apply):

____ Solo ____ Group ____ Partnership ____ Research ____ Teaching
____ Administrative ____ Government ____ Other(describe): _____

Addresses (check one for preferred mailing address; list any additional office locations on a separate page):

___ Professional: Address:_____
City/State/Zip: _____ Phone: _____

___ Home: Address: _____
City/State/Zip: _____ Phone: _____

Type of Membership Applying For:

____ Active, Regular (MD/DO/DC/DDS/ND/DVM/PA/NP in practice)
____ Active, Resident (MD/DO/DC/DDS/ND/DVM/PA/NP in training)
____ Associate (Other Licensed health professionals)
____ Student (Enrolled in an accredited MD/MO/DC/DDS /ND/DVM/PA/NP school)

Please enclose copies of the following documents with your application:

1. MD/DO/DC/DDS/ND/DVM/PA/NP certificate (or other health certificate)
2. Homeopathic degree certificate(s)
3. Current State license(s)
4. Any other certificate(s) applicable to this application

Please submit a separate sheet for any information on the next two pages which cannot be included in the spaces provided

Education:

Undergraduate University

Name	Location	Degree	Dates
Name	Location	Degree	Dates

Graduate University

Name	Location	Degree	Dates
Name	Location	Degree	Dates

Medical School

Name	Location	Degree	Dates
Name	Location	Degree	Dates

Internships/Residencies/Fellowships

Name	Location	Speciality	Dates
Name	Location	Speciality	Dates
Name	Location	Speciality	Dates
Name	Location	Speciality	Dates

Medical/Specialty Society Memberships

Current and Previous Hospital Privileges (list chronologically starting with the most recent)

Hospital	Dates	Type of Affiliation
Hospital	Dates	Type of Affiliation

Education (continued):

Homeopathic Seminars/Courses/Preceptors

Dates	Description	Location	Instructors/Sponsor
Dates	Description	Location	Instructors/Sponsor
Dates	Description	Location	Instructors/Sponsor
Dates	Description	Location	Instructors/Sponsor

Homeopathic Society Memberships

Teaching Positions:

Title	School	Subject	Dates
Title	School	Subject	Dates

Publications: Give title, journal, volume and year

Clinical Practice: Describe type of homeopathy you practice (i.e. classical, anthroposophical etc.)

How long have you been practicing homeopathy?

How long have you practiced homeopathy at your present locations?

If you have practiced elsewhere, give locations and dates

Please Answer The Following Questions:

	NO	YES
Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical or ganization?	_____	_____
Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked or voluntarily surrendered?	_____	_____
Have your privileges at any hospital ever been suspended, denied, diminished, revoked or not renewed?	_____	_____
Have your ever been convicted or found guilty by any court of a felony or other serious crime?	_____	_____

(If you have answered yes to any of the above, please attach a separate sheet listing details of each question)

References: (List two professional references, giving complete name, address and phone number . Please note how long you have known this reference and in what capacity)

1. Name: _____ Address _____

   City/State/Zip: _____ Phone: _____

   Length of Acquaintance/Capacity: _____

2. Name: _____ Address _____

   City/State/Zip: _____ Phone: _____

   Length of Acquaintance/Capacity: _____

I, (print name) _____, hereby apply for membership in the Illinois Homeopathic Medical Association (IHMA).

I hereby grant permission for the IHMA and its membership committee, in the processing of this application, to obtain any information deemed necessary to evaluate my application from any of the parties or sources listed in this application.

I hereby release, and hold harmless from any liability or loss, the IHMA, its of ficers, agents, employees and members, for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications and hereby release from any liability any and all individuals and or ganizations, who in good faith and without malice, provide information to the IHMA, or to its authorized representatives, concerning my qualifications for membership.

Further, I believe that to the best of my knowledge I have answered the above questions fully and honestly . I agree to abide by the bylaws of the IHMA, to pay all dues, fees and assessments in a timely fashion, and to conduct my practice in a ethical manner .

Signature: _____ **Date:** _____

PLEASE MAIL YOUR APPLICATION, COPIES OF CERTIFICATES AND MEMBERSHIP FEE TO THE IHMA AT: 400 E. 22nd Street, Suite F , Lombard, IL 60148.

ILLINOIS HOMEOPATHIC MEDICAL ASSOCIATION (IHMA)
ANNUAL MEMBERSHIP RENEWAL/APPLICATION FORM

www.homeopathyillinois.org

RENEWAL / NEW* ( ) MD, DO, DC, DDS, ND, DVM, PA, NP $100
( ) ASSOCIATE MEMBER $75
( ) STUDENT/RESIDENT $50

MAILING ADDRESS: **Please note any changes below.**

Name: _____
Address: _____
City, State, Zip _____

WEBSITE LISTING: **Please note any changes below.**
(Active members only)

Name _____
Clinic Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Website: _____
Email: _____

Other database information on file: **Please note any changes below.**
Email: _____
Fax: _____
Cell/home phone: _____
Medical License No: _____

***NEW APPLICANTS** must include documents as outlined on the Membership Application which appears above.

DUE DATE for renewal and continued inclusion on the website with incorporation of noted changes must be received by _____.

Make check payable to IHMA. Send the check and this completed form to: **IHMA, Attention Treasurer, 400 E. 22nd Street, Suite F, Lombard, IL 60148.**

New members will receive a signed IHMA Membership Certificate, be added to our membership database and online practitioner list (active members only), and receive a Password to access the "Members Only" section of the Website.
Office use only:

( ) check received date: _____ BY: _____
( ) database updated: _____ BY: _____
( ) certificate sent date: _____ BY: _____
( ) confirmation, minutes and password sent date: _____ BY: _____