



Dominican Medical Association (DMA), Inc. New York.

A non for profit organization
Founded in April 26th 1997

Membership Application

Biographical Information Male___ Female___ Nationality_____

Last name

First name

M.I.

DOB

Mailing address

City

Province/State/County

Country

Postal Code

E-mail address

Office Telephone

Home Telephone

Fax Number

Migratory Status: US Citizen___ US Resident ___ Visa/Type ___ Other ___

Professional Training

Medical School/Graduate Level Training

Medical school

Started

Finished

Degree

City/Country

Certification (If Applicable)

Date _____ Board Specialty _____

Country _____ Licensing Entity _____

Postgraduate Training (Including Residency Training)

Training Program/school _____

City/Country_____

Started (Month/Year) _____ Finished(Month /Year)_____ Specialty_____

Membership in Medical Society

Name _____ Location _____

Current Job: Employer _____ Title/Position _____

References (Could be a Health Professional, DMA member, Community Leader, Etc.)

Name_____ Telephone Number _____

Name_____ Telephone Number _____

Ethics

Have your license practice ever be revoked or suspended _____ — yes — no

Are you currently charge with illegal or unethical professional conduct ___ yes ___ no

Have you ever found guilty of illegal or unethical conduct _____ — yes — no

If yes, to any of the three preceding questions please furnish confidential details to DMA.

Agreement

I certify that the above information is accurate; I understand that inaccurate information can invalidate my application. My signature means that I agree with the conditions on this application

Signature

Date

Official use (Do not write below)

Date received _____ **Date approved** _____

No accepted /Date/reasons _____

President

Secretary