# NEW YORK STATE PODIATRIC MEDICAL ASSOCIATION

Thank you for your interest in joining the New York State Podiatric Medical Association!

Applications can be faxed to 646-672-9344; emailed to rdoshi@nyspma.org; or mailed to NYSPMA, Attn: Rashmi Doshi, 555 Eighth Avenue, Suite 1902, New York, NY 10018.

In addition to the application, please include the following required documents:

- Copy of your **New York State** license
- Resume/CV
- Proof of malpractice insurance

The Association's fiscal year begins May 1, and your dues will be pro-rated to the date on which your membership will begin.

We look forward to welcoming you as a new member!

Sincerely,
Rashmi Doshi

Membership Director

American Podiatric Medical Association

# American Podiatric Medical Association

Web site: www.apma.org
E-mail: membership_ask_apma@apma.org
1-800-ASK-APMA

## Application for Membership

I hereby apply for membership in the component association of the state in which I have my principal practice and to the American Podiatric Medical Association (APMA). If elected, I agree to uphold and abide by the purposes, bylaws, code of ethics, and all rules and regulations of my component association and the APMA. I understand that no one has an automatic right to be elected to membership in this voluntary organization.

**Please type or print clearly.**

Attach additional sheet of paper if needed.

Birth date, gender, and ethnic group are requested for statistical purposes.

Last Name _____ First _____ Middle _____

Previous Last Name *(changed due to marriage, divorce, etc.)* _____

Birth Date _____ / _____ / _____ Nickname _____

Gender: ❑ M ❑ F Ethnic Group *(for demographic use only)*: ❑ Caucasian ❑ African American ❑ Hispanic ❑ Asian/Pacific ❑ American Indian ❑ Other _____

Spouse's Name_____ US Citizen *(optional)*: ❑ Yes ❑ No

**Complete all addresses below.**

Please note your preferred mailing address by placing a check mark in the box to the left of that address.

*Your home address is essential for identifying and contacting your federal and state legislators through APMA's e-Advocacy program.

**Please include your e-mail address as APMA communicates many important issues via e-mail.

❑ **Home Address*:** _____

_____ County _____

Telephone ( ) _____ Fax ( ) _____

Home e-mail**: _____ Cell ( ) _____

Pager ( ) _____

❑ **Principal Office/Residency Address:** _____

_____ County _____

Telephone ( ) _____ Fax ( ) _____

Office e-mail**: _____ Office Web Site: _____

❑ **Second Office Address:** _____

_____ County _____

Telephone ( ) _____ Fax ( ) _____

Office e-mail**: _____ Office Web Site: _____

❑ **Third Office Address:** _____

_____ County _____

Telephone ( ) _____ Fax ( ) _____

Office e-mail:** _____ Office Web Site: _____

*If you have more than three office addresses, please list on a separate sheet.*

## Education

**Undergraduate Degree**

Year _____ State _____ Institution _____ Degree _____

**Graduate Degree**

Year _____ State _____ Institution _____ Degree _____

**Podiatric Medical Degree**

*(See back panel for listings)*

Check College Below Year of Graduation _____ ❑ Arizona ❑ Barry ❑ California

❑ Des Moines ❑ New York ❑ Ohio ❑ Temple ❑ Scholl ❑ Western ❑ Other

**Postgraduate Education**

If you have more than two fellowships or residencies, please list on a separate sheet.

❑ Yes *(If yes, complete)* ❑ No

❑ Preceptorship

❑ Fellowship

❑ Residency *(check one only)*:

❑ Rotating Podiatric Residency (RPR) ❑ Podiatric Orthopedic Residency (POR)

❑ Primary Podiatric Medical Residency (PPMR) ❑ Primary Surgical Residency (PSR)

❑ Podiatric Medicine and Surgery Residency (PM+S)

Begin Date_____ State_____ Institution_____ Completion Date_____
mo / yr mo / yr

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❑ Fellowship

❑ Residency *(check one only)*:

❑ Rotating Podiatric Residency (RPR) ❑ Podiatric Orthopedic Residency (POR)

❑ Primary Podiatric Medical Residency (PPMR) ❑ Primary Surgical Residency (PSR)

❑ Podiatric Medicine and Surgery Residency (PM+S)

Begin Date_____ State_____ Institution_____ Completion Date_____
mo / yr mo / yr

## Military

**Military Service**

❑ USA ❑ USAF ❑ USN ❑ USMC ❑ USCG Other _____

Date Entered_____ Date Separated_____ Current Rank_____

❑ Reserves *If yes, branch of service* _____

## Professional Licensure

**Podiatric Medical Licenses**

Year_____ State_____ Number_____ Year_____ State_____ Number_____

Year_____ State_____ Number_____ Year_____ State_____ Number_____

Year_____ State_____ Number_____ Year_____ State_____ Number_____

Have you ever had a license to practice podiatric medicine suspended, denied, or revoked by any licensure authority?

❑ Yes (*If yes, please explain on a separate sheet.)* ❑ No

Are you currently, or have you ever been, on probation, suspension, or investigation by any licensure authority, state, or federal agency?

❑ Yes (*If yes, please explain on a separate sheet.)* ❑ No

## Podiatric Medical Practice

**Original Practice Start Date**

Month_____ Day_____ Year_____

## APMA-Recognized Organizations

(check only those in which you have certification/membership)

**Board Certification**

*(See back panel for listings)* If you are interested in learning more about qualification or certification in these organizations, go to www.apma.org/certifyingboards

❑ ABPS ❑ ABPOPPM

**Affiliated Membership**

*(See back panel for listings)* If you are interested in learning more about membership in these organizations, go to www.apma.org/affiliated

❑ AAHHP ❑ AAPPM ❑ AAPSM ❑ AAWP ❑ ACFAOM

❑ ACFAP ❑ AENS ❑ APMWA ❑ ASPD ❑ ASPM ❑ ASPS

## Previous Member of APMA

❑ Yes *(If yes, complete)* ❑ No

Dates _____ Component Association _____

## Signature/Instructions

Please be aware that you may be required to provide additional documentation (copy of all state licenses, business card, sample of stationery, etc.) to your component society.

I understand that dual membership (state component and national association) is required to be a member in good standing. I agree not to represent myself as a member of APMA or my component, if for any reason, I cease to be a member in good standing. I also understand that a portion of my annual dues is in payment for a one year subscription for the ***APMA NEWS*** and for the ***Journal of the American Podiatric Medical Association***. I agree that incomplete or false information may be grounds for denial or termination of membership.

APMA dues are not deductible as a charitable contribution for federal tax purposes but may be deductible as a business expense.

***If you are a practicing DPM, it is important to contact the state component in which your primary practice is located.*** Contact information can be found on-line at www.apma.org/StateComponents. Your component will inform you of the amount of dues to remit as well as any other required documentation. An overview of membership processing procedures of each component can be viewed at www.apma.org/MembershipProcess. Your completed application and dues payment must be sent directly to your component, not the APMA.

***If you are a DPM in post-graduate training, send your completed application and dues payment directly to APMA.*** A current dues chart for DPMs in post-graduate training can be viewed at www.apma.org/PostGraduateDuesSchedule.

If you have any questions, please contact the APMA Membership Services department at 1-800-ASK-APMA.

Applicant Signature: _____, DPM Date: _____

I was recruited for APMA membership by the following APMA member:

_____

## Listing of Podiatric Medical Colleges

| | |
|---|---|
| Arizona: | Arizona Podiatric Medicine Program at Midwestern University—Glendale |
| Barry: | Barry University School of Podiatric Medicine |
| California: | California School of Podiatric Medicine at Samuel Merritt University |
| Des Moines: | Des Moines University College of Podiatric Medicine & Surgery |
| New York: | New York College of Podiatric Medicine |
| Ohio: | Ohio College of Podiatric Medicine |
| Temple: | Temple University School of Podiatric Medicine |
| Scholl: | Dr. William M. Scholl College of Podiatric Medicine at Rosalind Franklin University of Medicine & Science |
| Western: | Western University of Health Sciences College of Podiatric Medicine |

## Listing of Boards

If you are interested in learning more about qualification or certification in these organizations, go to www.apma.org/certifyingboards

| | |
|---|---|
| ABPOPPM | American Board of Podiatric Orthopedics and Primary Podiatric Medicine |
| ABPS | American Board of Podiatric Surgery |

## Listing of Affiliated Organizations

If you are interested in learning more about membership in these organizations, go to www.apma.org/affiliated

| | |
|---|---|
| AAHHP | American Association of Hospital and Healthcare Podiatrists |
| AAPPM | American Academy of Podiatric Practice Management |
| AAPSM | American Academy of Podiatric Sports Medicine |
| AAWP | American Association for Women Podiatrists |
| ACFAOM | American College of Foot and Ankle Orthopedics and Medicine |
| ACFAP | American College of Foot and Ankle Pediatrics |
| AENS | Association of Extremity Nerve Surgeons |
| APMWA | American Podiatric Medical Writers' Association |
| ASPD | American Society of Podiatric Dermatology |
| ASPM | American Society of Podiatric Medicine |
| ASPS | American Society of Podiatric Surgeons |

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**For Component Society Use**

Component name:_____

Division (If applicable):_____

Date application was received:_____

Date sent to APMA:_____

Join date:_____

Member category:_____

**For APMA Use Only**

Dues Amount _____

Member No. _____

Member Type _____

Date Received _____

Elect Date _____

# Consent to Release of Information

I hereby consent to the release of all information, and release from any liability any and all individuals and organizations providing such information to the New York State Podiatric Medical Association or its authorized representatives, in good faith and without malice, concerning my professional competence, ethics, character and other qualifications for my joining the New York State Podiatric Medical Association.

I certify that the information contained in this application is complete and correct to the best of my knowledge, and I understand that the falsification of this information is grounds for revocation of approval.

**_____, DPM**
**Name of Podiatrist**

**_____**
**Signature**

**Date:** **_____**

**Address:** **_____**

**_____**

**_____**

**Phone:(_____) _____- _____**

**Name: _____, DPM**

**HISTORY OF PRACTICE (All questions must be answered fully & accurately)**

1. **Has your current or any past license to practice your profession ever been suspended within the past 10 years?**
   **_____ Yes _____ No If yes, please explain below.**

2. **Have your privileges at any hospital ever been denied, suspended, or revoked?**
   **_____ Yes _____ No If yes, please explain below.**

3. **Have you ever been denied membership or been subject to reprimand, censure or otherwise disciplined by any medical organization?**
   **_____ Yes _____ No If yes, please explain below.**

4. **Has your narcotics registration ever been suspended, restricted, cancelled or relinquished?**
   **_____ Yes _____ No If yes, please explain below.**

5. **Do you have malpractice insurance? _____Yes _____ No**
   **Please return a current Certificate of Insurance with this form.**

6. **Has your malpractice insurance ever been suspended, cancelled or not renewed?**
   **_____ Yes _____ No If yes, please explain below.**

7. **Have you ever been party to a professional malpractice suit in which a judgment of liability was entered against you or in which a suit was resolved by a settlement or payment by you or your insurer?**
   **_____ Yes _____ No If yes, please explain below.**

8. **Have you ever been suspended as a Medicare or Medicaid Provider in the past 10 years?**
   **_____ Yes _____ No If yes, please explain below.**

9. **Have you ever had treatment for chemical dependency or have you ever been in a drug or alcohol rehabilitation program?**
   **_____ Yes _____ No If yes, please explain below.**

10. **Have you ever been convicted of any criminal charges other than minor traffic offenses?**
    **_____ Yes _____ No If yes, please explain below.**

11. **Have you ever been convicted of any crime related to your practice of medicine, including Medicare or Medicaid related fines?**
    **_____ Yes _____ No If yes, please explain below.**