



P O Box 28415 Atlanta, GA 30358  
Phone: 888-215-0553 Fax: 877-756-8936  
Email: feliciahorton@docs4patientcare.org

Type of Membership:

Charter (Gold) \$1,000  Silver \$250  Residents/Medical Students/Military \$0

Name \_\_\_\_\_  
First Middle Last

License # \_\_\_\_\_ State \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Practice Name: \_\_\_\_\_

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

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Cell \_\_\_\_\_

Email: \_\_\_\_\_@\_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Specialty \_\_\_\_\_  
Primary Secondary

Board Certifications: \_\_\_\_\_

Medical Education:

School: \_\_\_\_\_  
Name City, State

Degree: \_\_\_\_\_ Date of Graduation \_\_\_\_\_

Residencies, Internships & Fellowship	Date of Graduation	Program Director
_____	_____	_____
_____	_____	_____
_____	_____	_____

Specialty Society Membership: \_\_\_\_\_

The undersigned applicant: hereby certifies that all of the information contained in the application is true and correct; hereby authorizes Association of Docs4Patient Care, and its authorized representatives to consult with any and all persons and obtain any and all documents necessary to verify the accordance of the information contained in this application; hereby releases the Association of Docs 4 Patient Care, and it authorized representatives and all persons and organizations who provide information to the Association of Docs 4 Patient Care or its authorized representatives in accordance with this application from any liability arising out of the above described authorization actions; hereby agrees to promptly notify the Associations of Docs 4 Patient Care, in writing, in the event of a material change in any of the information provided by the Applicant in this application.

This \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Applicant Signature