Academy of Medicine of Cincinnati Member Data

Member: First Name _____ MI____ Last Name_____

MD, DO Other_____ Specialty_____

Office: Street Address_____

City_____ State_____ Zip_____

Office: Phone_____Fax_____Email_____

Office Manager: Name_____Email_____

Group Name_____ Health System Affiliation_____

Home: Street Address_____

City_____ State_____ Zip_____

Cell phone_____ Other email_____

Preferred email: ◯ Office ◯ Other

Preferred mail location: ◯ Office ◯ Home

Preferred phone: ◯ Office ◯ Cell

Thank you. Please return to membership@academyofmedicine.org, fax to 513-721-4378, or mail to Academy of Medicine of Cincinnati, 7265 Kenwood Road, Suite 315, Cincinnati, OH 45236.

For Academy of Medicine use: Date received_____

Follow-up needed ____yes ____no. If yes, date completed_____

May 2020