

Application for Membership

Association of Physicians of Ross University in Dominica

**P. O. Box 266, Portsmouth,
Commonwealth of Dominica, West Indies
Tel: 809 - 445 - 5355 Ext. 260
Fax: 809 - 445 - 5383**

I,, having accepted the goals and procedures set forth in the Constitution and bylaws of the association, hereby apply for membership in the association. I also assert that the information given below is true and factual to the best of my knowledge. By accepting this membership I promise to uphold and cherish the profession of medical practice and abide by the ethical standards set forth by the profession.

Date: Signature:

1. Name (Last, first)
2. Highest Degree and/or Certifications
(With dates and University name)
3. Licensed in (States, Countries),
.....,
4. Address:
.....
5. Phone Number:
6. E-mail address if any
7. Faculty appointment at Ross University

8. Field of Speciality
9. Special interests and hobbies
10. Have you ever been convicted of or charged with a felony? Yes/No
(If yes attach an explanation)
11. Based on disciplinary action, have you ever been terminated or asked to resign from;
(a) membership of a professional organization, (b) faculty position, or © medical staff
privileges? Yes/No (If yes, please attach an explanation.

(Please attach two recent letters of reference)

For Office use only:

Action taken:

1. Reviewed _____ (Date:)
2. Approved _____ (Date:)
3. Referred to Ethics Committee _____ (Date:)
4. Referred to Executive Committee _____ (Date:)
5. Denied _____ (Date:)

Signed _____

Secretary

The Annual Membership Fee is \$ 150.00