

I wish to participate in Rhode Island's physician community!

RIMS is a vehicle of support for local physicians, which we prove through our advocacy, professionalism, and drive for the advancement of health care. We are a

Society that is run by and for doctors, and at 207 years old we remain a ready vehicle for effective leadership in the practice of medicine.



"It is better to have a seat at the table than to be on the menu..."
Diane Siedlecki, MD,
internal medicine

Your first step is completing this RIMS Membership Application

Full name _____

Home address _____

Degree(s) _____

Date of birth _____

Male _____ Female _____

Home telephone _____

Cell phone _____

Primary e-mail address _____

(RIMS' monthly RI Medical Journal is an electronic publication only; please share your preferred e-mail address)

Primary office address _____

Primary office telephone _____

Primary office fax _____

Secondary office address _____

Secondary office telephone _____

Secondary office fax _____

Preferred mailing address

All mail to: office home **or**
please indicate address for each of the following:
Membership dues billing: office home
Non-dues mailings (includes newsletters, annual directory of members, etc.): office home

Many patients call RIMS looking for a new doctor.
Do you want RIMS to refer such callers to you?

yes no

Medical school _____

Graduation year _____

Primary specialty _____

Board certified? yes no

Secondary specialty _____

Board certified? yes no

Membership categories

- Full Active (\$575)
- First year of practice (\$135)
- Second year of practice (\$135)
- Third year of practice (\$250)
- Fourth year of practice (\$360)
- Spousal discount (\$330 for second RIMS member)
- Part time (20 hours or less per week) (\$330)
- Resident/fellow (\$60)
- Military (Active Duty) (No charge)
- Lifetime (Retired for 5+ Years) (\$250)
- Physician assistant (\$70)
- Affiliate (\$70)
- Retired (\$70)
- Medical student (No charge)
- PA student (No charge for RIAPA Members)

A check in the amount of \$_____ is included.
Please make checks payable to "RI Medical Society".
Mail to: 405 Promenade St. Ste. A, Providence, RI 02908

Credit Card Payment: VISA MC AMEX

Name on Card: _____

Card Number: _____

Expiration Date: _____

Billing Address: office home