



## American Medical Association

Helping doctors help patients  
Telephone: 800-621-8335  
Fax: 312 464-5900

### AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA). Profiles also can be ordered online through the **AMA Profile Service** web site located at [www.ama-assn.org/go/amaprofiles](http://www.ama-assn.org/go/amaprofiles). AMA Customer Service is available for ordering assistance at 800-621-8335, 24 hours a day, seven days a week.

**\*\*\*Join or renew your AMA membership today -- call 800-AMA-3211\*\*\***

#### Indicate AMA Membership status:

<input type="checkbox"/> Member physician	No charge
<input type="checkbox"/> Nonmember physician	\$37 per profile*

**Standard Mail Service** (within 10 business days) \*Prices are subject to change without advance notice.

Credit card payment is accepted. Orders faxed to the AMA must include credit card information for billing purposes. Checks should be made payable to: **American Medical Association, 75 Remittance Drive, Suite #6397, Chicago IL 60675-6397.**

☐ VISA ☐ American Express ☐ MasterCard Charge Amount: \$ \_\_\_\_\_

Credit Card Number \_\_\_\_\_ Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name on Credit Card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Approval Signature \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_

#### Part 1: AMA Physician Profile delivery information

Please send my profile to the following state licensing board:

Board Name: \_\_\_\_\_

*NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.*

#### Part 2: Physician information

Physician Name (first, middle, last, suffix) \_\_\_\_\_

Former/Maiden Name \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

E-mail Address \_\_\_\_\_

Check here if you would like to receive e-mails about AMA advocacy initiatives, news for physicians, and AMA products and services.

Preferred Mailing Street Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
Telephone Number

The above address is my OFFICE ☐ HOME ☐ OTHER ☐

**If address is home or other, please complete this section.**

Primary Office Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_  
Office Telephone Number

### Part 3: Medical education and other information

Medical School of Graduation \_\_\_\_\_

Year of Graduation \_\_\_\_\_

ECFMG Number \_\_\_\_\_

### Physician agreement

**Agreement must be signed in order to process your request.**

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X \_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date