



Organized Medical Staff Section

Please complete, sign and fax (312-464-5845) this certification form today to identify or designate an OMSS representative from your hospital or health care delivery system.

Designated physician's name		
Medical education number		
Mailing address		
City	State	Zip code
Office telephone	Fax number	E-mail address
Hospital/delivery system name		

Delivery system entity: (e.g., hospital, group practice with three or more physicians, independent practice association, physician hospital organization, managed care organization, medical service organization, etc.)

Hospital/delivery system address		
City	State	Zip code
Hospital/delivery system telephone number address	Fax number	E-mail

I hereby certify that the physician named here is a member of the American Medical Association, a member of the medical staff or a resident/fellow affiliated with the hospital or delivery system, and has been selected by the medical staff as our representative to the Organized Medical Staff Section of the American Medical Association.

President or Secretary of Medical Staff signature Date