

Collier County Medical Society Membership Application

Membership Rate Information 2008

CCMS 1st Time Member \$200



Please return application to:

Collier County Medical Society
 1148 Goodlette Road North
 Naples, FL 34102
 Phone (239) 435-7727 Fax (239) 435-7790

PERSONAL INFORMATION (please print or type)

Last Name _____ First _____ Middle _____ MD DO

Gender: Male Female Date of Birth: ___/___/___ Spouse's Full Name: _____

Practice Name: _____ Administrator: _____

Practice Type: Solo Group Employed Government Based Other Practicing in Naples since ___/___/___

Primary Specialty: _____ Secondary Specialty: _____

EDUCATION Institution Location Degree

Medical School: _____ Date: _____

Internship: _____ Date: _____

Residency: _____ Date: _____

Fellowship: _____ Date: _____

BOARD CERTIFICATIONS:

Name of Board: _____ certified in _____ Date: _____

Name of Board: _____ certified in _____ Date: _____

HOSPITAL AFFILIATIONS:

Hospital (Primary) _____ City: _____

Hospital (Secondary) _____ City: _____

Please list the name and address of a local physician as a personal reference: _____

Please include a recent photograph of yourself for our directory.

OFFICE ADDRESS HOME ADDRESS

Office Address _____ Office City/State/Zip _____ Office Phone _____ Office Fax _____ Email Address _____	Home Address _____ Home City/State/Zip _____ Home Phone _____ Home FAX _____ Email Address _____
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MEMBERSHIP APPLICATION & QUALIFICATION QUESTIONS

Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign and date.

If you answer yes to any of these questions, please attach full information.

- Yes No
- Have you ever been convicted of fraud or a felony?
- Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.
- Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the information submitted in this application will be verified I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society(ies).

The foregoing information is true and complete.

Signature _____ Date _____

PAY BY CREDIT CARD (OPTIONAL)

Name on Card: _____ Exp. Date _____ Visa Master Card

Amount: _____ Card #: _____ Signature: _____

The endorsement, deposit or negotiation of an applicant's check does not constitute admission into or acceptance of membership by the CMS or FMA. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a check refunding the amount sent.