Collier County Medical Society
Retired Membership Application

Membership Rate Information 2007

$150 Retired Member

Please return application to:

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

Please make your check payable to the Collier County Medical Society (CCMS)

PERSONAL INFORMATION (please print or type)

______________________________ ☐ MD ☐ DO
Last Name First Middle

AMA Medical Education #: ______________ FL Medical License #: ______________

Gender: ☐ Male ☐ Female Date of Birth: ____/ ______ / _______ Spouse's Full Name: ______________

Last Practice/Group Name: ______________

Practice Type: ☐ Solo ☐ Group ☐ Employed ☐ Government Based ☐ Academic ☐ Other

Primary Specialty: ______________ Secondary Specialty: ______________

EDUCATION:
Medical School: ______________Degree: ______________ Date: ____________

BOARD CERTIFICATIONS:
Name of Board: ______________certified in ______________ Date: ___________

Name of Board: ______________certified in ______________ Date: ___________

MAILING INFORMATION

____
Home Address

____
Home City/State/Zip

____
Home Phone

____
Home FAX

____
Email Address

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.