Collier County Medical Society
Retired Membership Enrollment Form

Membership dues

☐ *Retired Members $200*
☐ *CCMS PAC $100 (optional)*

Please return form to:
Collier County Medical Society
1148 Goodlette Road North
Naples, FL 34102
Ph (239) 435-7727 Fax (239) 435-7790
info@ccmsonline.org

If paying by check, please make 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/Partner Full Name: _____
**Spouses may contact the CCMS Alliance at www.ccmsalliance.info for membership information.*

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: _____

Who referred you to CCMS: _____

CONTACT INFORMATION

_____
Home Address

_____
Home City/State/Zip

_____
Home Phone

_____
Home FAX

_____
Email Address

Home and email contact information is confidential, for CCMS business use only.

MEMBERSHIP 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 form will be verified I hereby authorize other organizations having information relating to this form, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my form 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) – Please do not email unencrypted credit card information

Total Payment $_____ ☐Check enclosed ☐Visa ☐ MasterCard ☐AMEX Card #:_____

Name on Card:_____ Signature:_____

Expiration Date:_____ Billing Address:_____

The endorsement, deposit or negotiation of payment does not constitute admission into or acceptance of membership by CCMS. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. If membership enrollment is not completed, CCMS will refund the amount sent. Tax Deduction information: The Revenue Reconciliation Act of 1993 states that association dues used for lobbying activities are not deductible as a business expense. While Association dues are not tax deductible as charitable contributions for federal income tax purposes, they may be tax deductible under other provisions of the Internal Revenue Code. Contributions to CCMS PAC are not tax deductible.