

2012 Seminole County Medical Society Membership Application



Return Application and Membership Dues to:

Seminole County Medical Society
PO Box 951450
Lake Mary, FL 32795-1450

407-804-9535 / Fax 407-804-9445
scms@scmsociety.com / www.scmsociety.com

2012 Membership Rates Please Check One:

- Full Active.....\$275
- 1st Year only in Sem. Co... \$200
- Associate Member*..... \$100
- Retired..... \$ 25

* Dual member with other CMS

PERSONAL INFORMATION (please print or type)

Date: _____

_____ MD DO
Last Name First Middle

AMA/AOA Medical Education #: _____

FL Medical License #: _____

Sex: Male Female Date of Birth: ____/____/____ Place of Birth: _____

Spouse's Full Name: _____

Practice/Group Name: _____

Website Address: _____ Office Manager Name & Email: _____

Practice Type: Solo Group Employed Government Based Academic Other

Primary Specialty: _____

Secondary Specialty: _____

Name of FMA/SCMS Member that recruited you: _____

MAILING INFORMATION

Please provide both addresses.

Do you prefer to receive mail at HOME OFFICE

Office Address Home Address

Office City/State/Zip Home City/State/Zip

Office Phone Home Phone

Office FAX Home FAX

Email Address SPOUSE Email Address

EDUCATION

Medical School: _____ Degree: _____

City, State, Country: _____ Date: _____

Residency/Fellowship: _____ Date Completed: _____

City, State, Country: _____



BOARD CERTIFICATIONS

1. Name of Board: _____

Certified in _____ Date: _____

2. Name of Board: _____

Certified in _____ Date: _____

HOSPITAL AFFILIATIONS

1. Hospital (Primary) _____

City: _____

2. Hospital (Secondary) _____

City: _____

MEMBERSHIP APPLICATION & QUALIFICATION QUESTIONS

Members abide by the American Medical Association Principles of Medical Ethics and bylaws. 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 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 CHECK OR CREDIT CARD

Check enclosed for \$ _____ payable to SCMS. Check # _____ Date: _____

Charge to my credit card Visa Master Card Amount: \$ _____

Account #: _____ Exp. Date: _____

Three Digit Security Code (found near signature on back of card): _____

Name on Card: _____ Signature: _____

The endorsement, deposit or negotiation of an applicant's payment does not constitute admission into or acceptance of membership by the CMS or FMA. Monies 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 in.

Thank you!

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