For office use only

Dues have been received for: ❑ **Component** ❑ **CMS** ❑ **AMA** ❑ **MC** ❑ **AP** ❑ **COPIC** ❑ **AMA** **CMS #**_____

APPLICATION FOR MEDICAL SOCIETY MEMBERSHIP IN COLORADO

Please complete all parts of this application. **A check payable to the Colorado Medical Society in the amount of $_____ must accompany the application.** Colorado Medical Society membership requires membership in your local medical society. If you wish to join the American Medical Association at this time, add their dues to the amount indicated above.

Colorado Medical Society Dues : $_____ _____ Dues : $_____ (local medical society)

American Medical Association Dues : $_____ ❑ I wish to join the American Medical Association and have included their dues with my remittance.

Name: _____ MD ❑ Male ❑ Female
Last First Middle Degree

Primary Office: _____
Street Suite # City State Zip

Phone: (_____)_____ Fax: (_____)_____

E-mail address: _____ Web site address: _____

Type of practice: ____Solo ____Same Specialty Group ____Multi Specialty Group ____Faculty ____Administration _____Other (specify)

Present or anticipated local practice affiliation (e.g., name(s) of partners, group, etc.) and date you will begin active practice (if applicable): _____

_____

Home: _____ Phone: (_____)_____
Street Apt. # City State Zip

For my mailing address, please use: ❑ Office or ❑ Home ☛ In CMS Directory, please list: ❑ Office and/or ❑ Home

Date of Birth: _____ Place: _____ Spouse Name: _____
Month / Day / Year City / State / Country First Last

Colorado License: _____ _____ Other State License(s): _____ _____
Date Issued Number Date Issued / Number / State Date Issued / Number / State

Specialty: _____ Board Certification(s): _____
Certifying Board

_____
Certification Number Month / Day / Year Original Date of Certification Recertification Date Expiration Date

Medical Liability Insurance Carrier _____

COLORADO HOSPITAL MEDICAL STAFF PRIVILEGES:

_____
Full Name of Institution / City / State Began Mo / Yr - Ended Mo / Yr

_____
Full Name of Institution / City / State Began Mo / Yr - Ended Mo / Yr

_____
Full Name of Institution / City / State Began Mo / Yr - Ended Mo / Yr

PRACTICE HISTORY: (Include teaching appointments, military and public health service, private practice)

_____
Location Specialty / Branch of Service Began Mo / Yr - Ended Mo / Yr

_____
Location Specialty / Branch of Service Began Mo / Yr - Ended Mo / Yr

_____
Location Specialty / Branch of Service Began Mo / Yr - Ended Mo / Yr

MEDICAL SCHOOL: ECFMG # (Applicable to Medical Schools Outside of USA) _____

_____
Full Name of Institution / City / State Degree Mo / Yr

INTERNSHIP:

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

RESIDENCY:

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

FELLOWSHIP / PRECEPTORSHIP: (Circle one)

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

OTHER GRADUATE DEGREES:

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

Foreign Language(s) Spoken: _____

Have you ever been convicted of a felony? Yes _____ No _____

Have your hospital medical staff privileges ever been refused, revoked, suspended or reduced? Yes _____ No _____

Has your license to practice medicine ever been denied, restricted, suspended or revoked? Yes _____ No _____

Are there any judicial or regulatory actions pending which could result in denial, restrictions, suspension, or revocation of your license to practice medicine? Yes _____ No _____

Have you ever been expelled from or denied membership in a state or local medical society? Yes _____ No _____

Is there any pending review or disciplinary action with a state or local medical society regarding your membership? Yes _____ No _____

If you answered yes to any of the above questions, please explain on a separate page and attach to this application.

Have you previously been a member of the CMS or this component society: Yes _____ No _____ Date _____

If elected to membership, I agree to conduct myself professionally and personally according to the AMA Principles of Medical Ethics (enclosed) and to be governed and bound by the Constitution and Bylaws of the Society(ies) for which I am applying. Further, I hereby affirm that I have no physical, mental, or emotional condition which would impair my ability to provide an acceptable standard of medical care. I understand that submission of false or fraudulent information may result in denial of membership or expulsion from the society(ies).

I hereby release, and hold harmless from any liability or loss, the Society(ies) for which I am applying, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any and all individuals, organizations, and agencies or their authorized representatives from any liability concerning information provided about my professional competence, ethical conduct, character, and other qualifications for membership.

Applicant's Signature: _____ Date: _____

"Recommended by" signatures are required only if you are joining El Paso County Medical Society (one signature) or Weld County Medical Society (two signatures).

Recommended by: _____ _____
Signature Signature

_____ _____
Name typed or printed Name typed or printed

The undersigned officer of the Society, having fully considered this application and appropriate supporting documents recommends the following action:

Accepted _____ Rejected _____ Signature: _____ Date: _____