Rock Island County MEDICAL SOCIETY

2017 Membership Application

Illinois State Medical Society

Check one: _____Physician _____1st year _____2nd year _____3rd year _____4th year _____Resident _____Student

PERSONAL DATA

Last:_____ First:_____ Middle:_____ Degree:_____
(Entire name should be as shown on medical license) (MD/DO)

DOB: _____ SSN: _____ Gender: _____
mm/dd/yy (Male/Female)

Marital Status: _____ Spouse's Full Name: _____
(Single/Married)

_____ _____ _____ _____
Full Name of Medical School Country Graduation Year Board Certified/Year

_____ _____ _____ _____
IL State License Number First Year of Medical Practice-Date Primary Specialty Sub-specialty

Practice Type (Check all that apply):
_____Group _____Solo _____Academic _____Medical Research _____Administrative _____Employed _____Other_____

ADDRESS/COMMUNICATIONS INFORMATION (Please check the preferred address for ISMS correspondence)

_____Primary Office Street/PO Box _____

City/State/Zip _____

_____Home Street/PO Box _____

City/Sate/Zip _____

Practice/Group Name: _____

Email: _____

Office Phone: _____

Office Fax: _____

Home Phone: _____

Home Fax: _____

Office Manager: _____

Consent to Fax/E-mail: _____ Yes _____ No
Due to the federal communication regulations, it is necessary for ISMS to obtain written consent to continue distributing some information via fax and e-mail. By checking the box above and providing your fax number and e-mail address, you agree to receive from the association and its affiliates promotional notices or solicitations of the availability of goods or services and opportunities related to the practice of medicine. Please note ISMS does not sell or make available to the public its membership lists and will be providing the same type of communications as in the past such as HIPAA or other CME seminars and publication discounts available to members. You may opt out at any time by fax (312) 782-0554 or e-mail membership@isms.org

RESIDENCY/FELLOWSHIP INFORMATION

	Residency	Fellowship
Program Name	_____	_____
State	_____	_____
Year Completed	_____	_____

AFFILIATIONS:

Hospital Affiliation_____

Hospital Affiliation_____

Please Submit Application To:

Rock Island County Medical Society
PO Box 277
Bettendorf, IA 52722

Or email to qcmso@aol.com

Help Us Say Thank You

If you are joining ISMS at the suggestion of a current ISMS member, we would appreciate the opportunity to say thank you. Please indicate the ISMS member who referred you.

_____
(Name of the ISMS Member

DUES SUMMARY

_____ Rock Island County Medical Society	$395.00*	Mandatory
_____ ISMS	$570.00*	Mandatory
_____ IMPAC	$200.00	

Total $_____

With your credit card or EFT draft information below, we can process your membership application. *If you are a physician in your 1st year of practice dues are RICMS $79.00/ISMS $114.00, 2nd year of practice dues are RICMS $158.00/ISMS $228.00, 3rd year of practice dues are RICMS $237.00/ISMS $342.00 and 4th year of practice dues are RICMS $316.00/ISMS $456.00. Medical Students ISMS dues are $5.00, Residents $10.00

MEMBERSHIP PAYMENT OPTIONS (please select one):

Annual Payment

_____ ISMS + County $_____

_____ISMS, County + IMPAC $_____

Monthly Continuous Membership

_____ISMS + County 12 months $_____

_____ISMS + County + IMPAC 12 months $_____

(withdrawn on the 10th of each month)

PAYMENT INFORMATION

Please Check One:
1) _____ Visa _____MasterCard _____American Express **1A) _____**Personal Credit Card _____Corporate Credit Card

Total: $_____Expiration Date: _____/_____ CVV(3 or 4 Digit Security Code): _____

CC# _____-_____-_____-_____

2) _____ Checking/Savings Account

Name of Bank:_____

Routing Number: _____ Account Number: _____

Signature: _____ Date: _____

Membership Application and Qualification Questions

Members abide by the ISMS Code of Medical Ethics and the bylaws of the Society. 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 a full explanation on a separate sheet of paper.

Yes	*No*	
___	___	1. Have you ever been convicted of fraud or a felony?
___	___	2. 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 imposed sanctions or conditions.
___	___	3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that 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_____