2016 Membership Application

❑ Yes. I want to apply for membership. Please process my membership today. I am applying for:
❑ Scott County Medical Society ❑ Iowa Medical Society

Check one: ___Physician ___1st year ___2nd year___3rd year___4th year ___resident ___student

PERSONAL INFORMATION

Last Name (as shown on medical license) | First | Middle | Degree(MD/DO) | Gender(M/F)

Maiden Name (if applicable) | Spouse's Last Name | Spouse's First

Home Address | City/State/ Zip

Home Telephone | Home E-mail | Birth Date (m/d/y)

Place of birth | ME # if known | State License Number/State Issued

Medical School Name | Location | Graduation Year

Internship | Location | Graduation Year

Residency | Location | Graduation Year

Fellowship(s) | Location | Graduation Year

PROFESSIONAL PRACTICE INFORMATION

Primary Specialty | Board Certified?/Year

Subspecialty | Board Certified?/Year

Clinic Name | Preferred Mailing Address ☐ Office ☐ Home

Office Address | (____)_____ Telephone | (____)_____ Fax

City/State/Zip | Office E-mail

Hospital Affiliations | Languages Spoken Other Than English

Name of Physician(s) Who Referred You If Applicable

MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

Members abide by the AMA Principals 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

❑ ❑ 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

DUES

IMS Dues		Amount	$490
Scott County Dues		Amount	$395
		Total	$_____

(First and second year in practice dues are half in both categories. Please call SCMS at (563) 328-3390 if you have any questions.)

Make your check payable to Scott County Medical Society, 201 West 2nd Street, Suite 604, Davenport, IA 52801 or complete the credit card information below.

Charge to credit card: ☐Visa ☐MasterCard ☐Discover ☐Corporate ☐Personal

Card Number: _____ Zip Code:_____

Expiration: _____ CVV#: _____

Name on card: _____

_____ _____

Signature Date