2022 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 ___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, P.O. Box 277, Bettendorf, IA 52722 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