

APPLICATION FOR ASSOCIATE MEMBERSHIP

CONNECTICUT STATE MEDICAL SOCIETY

127 Washington Avenue, North Haven, CT 06473

Tel: (203) 865-0587 Fax: (203) 865-4997

NAME: _____
Last First Middle Initial Suffix

DATE OF BIRTH: _____ GENDER: M__ F__ APPLICATION DATE: _____

NAME OF PRACTICE: _____

NAMES OF MD SPONSORS:

1) _____

2) _____

PRIMARY OFFICE ADDRESS: _____

CITY _____ STATE _____ ZIP _____ -

PHONE (____) _____ EXT _____ FAX (____) _____

EMAIL ADDRESS _____ WEBSITE _____

OFFICE 2 ADDRESS: _____

CITY _____ STATE _____ ZIP _____ -

PHONE (____) _____ EXT _____ FAX(____) _____

EMAIL ADDRESS _____

RESIDENCE ADDRESS: _____

CITY _____ STATE _____ ZIP _____ -

TELEPHONE: (____) _____

EMAIL ADDRESS: _____

PREFERRED MAILING ADDRESS: PRIMARY _____ OFFICE2 _____ RESIDENCE _____

PRIMARY

SPECIALTY: _____ SPECIALTY 2 _____ SPECIALTY 3 _____

UNDERGRADUATE EDUCATION: _____

CITY, STATE, COUNTRY: _____

YEAR GRADUATED: _____ DEGREE: _____

CERTIFICATION: _____

POST GRADUATE STUDIES:

NAME OF INSTITUTION	CITY & STATE	FROM/TO	DEGREE
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HOSPITAL AFFILIATIONS: (PRESENT HOSPITAL/MEDICAL STAFF PRIVILEGES)

Hospital

Type of Privileges

NCCPA#: _____ NATIONAL PROVIDER IDENTIFER (NPI): _____

CT LICENSE #: _____ LICENSE DATE: _____ EXPIRATION: _____

YEAR YOU BEGAN PRACTICING IN THE STATE OF CT: _____

PROFESSIONAL MEMBERSHIPS: _____

LANGUAGES SPOKEN FLUENTLY: _____

PROFESSIONAL LIABILITY INSURER: _____

HAS YOUR LICENSE TO PRACTICE EVER BEEN DENIED, SUSPENDED OR REVOKED BY ANY GOVERNMENT AGENCY? Y ___ N ___

HAVE YOUR HOSPITAL MEDICAL STAFF PRIVILEGES EVER BEEN RESTRICTED, SUSPENDED OR REVOKED? Y ___ N ___

HAVE YOU EVER BEEN REPORTED TO, OR INVESTIGATED BY, A COUNTY OR STATE MEDICAL ASSOCIATION OR A CRIMINAL COURT ON CHARGES OF UNPROFESSIONAL CONDUCT OR CRIMINAL BEHAVIOR? Y ___ N ___

If you answered "yes" to any of the above three questions, please attach details.

PLEASE NAME TWO MEDICAL ASSOCIATION MEMBERS WHO ARE WILLING TO WRITE LETTERS OF REFERENCE:

Print full name, phone and email if known

I GIVE THE CSMS CREDENTIALS COMMITTEE, PERMISSION, IF NECESSARY TO INVESTIGATE THE STATEMENTS, AS WRITTEN.

Signature

Date

THIS AREA FOR CSMS USE ONLY

PRESENTED TO THE COUNCIL MEETING AND APPROVED FOR MEMBERSHIP.

DATE: _____ MD

Secretary