RESIDENT PHYSICIAN APPLICATION

Thank you for your interest in joining the Connecticut State Medical Society (CSMS). CSMS offers Society membership to residents who are/are not members of the AMA Resident Physician Section.

Date of application: _____NPI#: _____
Sex ____ Name: _____
DOB: _____
Mailing Address:
_____
Telephone: _____
Email:_____
Mobile phone number or pager:
_____
Hospital Residency:
_____
Expected Completion Date: _____
Specialty:_____
Premedical School: _____ Degree:_____
Year: _____ Medical School:_____
Degree: _____Year:_____
Location of Medical School (City, State, Country):
_____

☐ I wish to join CSMS at $20 for 12 months

Please make your check payable to CSMS, and send the completed application, along with your check to: 127 Washington Ave, East Bldg. Lower Level, North Haven, CT 06473

2025