CT Infectious Disease Society Membership Application

Date: _____

FULL NAME & SUFFIX:

_____

DATE OF BIRTH: _____ GENDER: M☐ F☐

PREFERRED MAILING ADDRESS: _____

CITY _____ STATE_____ ZIP_____-_____

PHONE (_____) _____ FAX (____)_____

PRIMARY EMAIL _____

MEMBERSHIP TYPE:

$75 - Infectious Disease Physician ☐ Non-Infectious Disease Physician ☐ Pharmacist ☐
APRN ☐ Infection Prevention/Control Practitioner ☐

$30 - Resident/Fellow ☐

INTEREST:

General Infectious Disease ☐ HIV ☐ Epidemiology ☐ Research ☐ Public Health ☐
Health Care Administration ☐

CURRENT STATE LICENSURE:

PROFESSION	NUMBER	EXPIRATION

_____

CURRENT NPI NUMBER: _____

ACADEMIC HISTORY:

MEDICAL SCHOOL: _____
LOCATION: _____
DEGREE: _____
DATES OF ATTENDANCE: _____

POST GRADUATE TRAINING: _____
LOCATION: _____
DEGREE: _____
DATES OF ATTENDANCE: _____

FELLOWSHIP: _____
LOCATION: _____
DEGREE: _____
DATES OF ATTENDANCE _____

Please make check payable to CIDS and mail application and payment to CIDS, 127 Washington Ave, East Building 1st FL, North Haven, CT 06473. We can be reached at (203) 865-0587 ext 111.