APPLICATION FOR MEMBERSHIP

Connecticut State Medical Society

127 Washington Avenue, North Haven, CT 06473 (203) 865-0587 Fax (203)-865-4997

☐ I also apply to the AMERICAN MEDICAL ASSOCIATION
515 North State Street, Chicago, IL 60610 (800) 262-3211

NAME: _____ ☐MALE ☐FEMALE
FIRST MIDDLE LAST (INDICATE M.D. OR D.O.)

PRIMARY OFFICE:

NAME OF PRACTICE: _____

_____
ADDRESS CITY STATE ZIP

OFFICE TELEPHONE: _____ **OFFICE FAX:** _____

NAME OF PRACTICE/OFFICE MANAGER: _____**PHONE & EXT**._____

EMAIL ADDRESS OF PRACTICE/OFFICE MANAGER: _____

HOME: _____
ADDRESS CITY STATE ZIP PHONE

PREFERRED MAILING ADDRESS: ☐ OFFICE ☐ HOME

EMAIL: _____ **WEBSITE:** _____

CT MEDICAL LICENSE #: _____ **DATE RECEIVED:** _____

DATE OF BIRTH: _____**NATIONAL PROVIDER IDENTIFICATION #:** _____

SPECIALTY: _____ **SUBSPECIALTY**: _____

ABMS BOARD CERTIFIED: ☐ YES ☐ NO BOARD: _____ DATE RCVD: _____

OTHER SPECIALTY TRAINING: _____

SPECIAL SERVICES: _____
(I.E., HOMEOPATHY; ACUPUNCTURE; LASER, ETC.)

UNDERGRADUATE COLLEGE OR UNIVERSITY: _____
NAME

_____
CITY STATE/COUNTRY DEGREE RECEIVED YEAR OF GRADUATION

MEDICAL SCHOOL: _____
NAME CITY STATE or COUNTRY

DATE OF GRADUATION: _____

- OVER -

CHRONOLOGICAL ACCOUNT OF APPLICANT'S TRAINING SINCE GRADUATION FROM MEDICAL SCHOOL:

HOSPITAL LOCATION SERVICE DATES

INTERNSHIP: _____

RESIDENCY:

PG1: _____

PG2: _____

PG3: _____

PG4: _____

FELLOWSHIP: _____

HOSPITAL PRIVILEGES:

_____
HOSPITAL TOWN STATUS

_____
HOSPITAL TOWN STATUS

_____
HOSPITAL TOWN STATUS

STARTED MEDICAL PRACTICE : _____
MONTH/YEAR

CHECK THOSE THAT BEST APPLY:

TYPE OF PRACTICE: ☐ SOLO ☐ PARTNERSHIP (2 PHYSICIANS) ☐ GROUP (3 OR MORE PHYSICIANS)

TYPE OF WORK: ☐ PATIENT CARE ☐ ACADEMIA ☐ MEDICAL ADMINISTRATION ☐ MEDICAL RESEARCH

☐ OTHER _____

WORK SETTING: ☐ PRIVATE PRACTICE ☐ GOVERNMENT ☐ INSURANCE CO. ☐ BUSINESS/INDUSTRY

☐ HOSPITAL, NURSING HOME, CLINIC, ETC. ☐ OTHER: _____

WORK STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ SEMI-RETIRED ☐ SABBATICAL ☐ MATERNITY LEAVE

☐ RETIRED DATE OF RETIREMENT: _____ ☐ OTHER: _____

LANGUAGES SPOKEN FLUENTLY: _____

USE SIGN LANGUAGE: ☐ YES ☐ NO **MAKE HOUSE CALLS**: ☐ YES ☐ NO

MILITARY EXPERIENCE: ☐ YES ☐ NO _____
BRANCH DATE(S) SERVED HIGHEST RANK

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED SPOUSE'S NAME: _____

PROFESSIONAL LIABILITY INSURER: _____

MEMBER OF CSMS-IPA: ☐ YES ☐ NO **MEMBER OF AMA**: ☐ YES ☐ NO

-OVER-

HAS YOUR LICENSE TO PRACTICE MEDICINE EVER BEEN DENIED, SUSPENDED OR REVOKED BY ANY GOVERNMENT AGENCY? ☐ YES ☐ NO

HAVE YOUR HOSPITAL MEDICAL STAFF PRIVILEGES EVER BEEN RESTRICTED, SUSPENDED OR REVOKED? ☐ YES ☐ NO

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? ☐ YES ☐ NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, ATTACH SHEET GIVING THE DETAILS.

_____

SIGNATURE DATE

PLEASE TURN OVER FOR DUES SCHEDULE

CONNECTICUT STATE MEDICAL SOCIETY
DUES SCHEDULE

	FULL	1st Year PRACTICE* New Applicant	2nd Year PRACTICE* New Applicant
CSMS	**$ 620.00**	**$ 310.00**	**$ 620.00**
AMA	**$ 420.00**	**$ 210.00**	**$ 315.00**
	$1040.00	**$ 520.00**	**$ 935.00**

***First or Second year of practice means newly out of residency/fellowship.**

PRORATED DUES SCHEDULE

Applications for membership received:

On or before June 30th:	**Full dues amount**
July 1st through October 31st:	**One-half dues amount**
On or After Nov. 1st:	**Dues will not be assessed for the current year. Please include payment for next year's dues.**

An applicant cannot be approved for membership until the applicant's dues obligation has been met.

Please send a check payable to the Connecticut State Medical Society, this page and a completed application to CSMS, 127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473.

Indicate Allocation of Dues

CSMS $_____
AMA $_____
TOTAL $_____

_____
Name

Questions: Please call 203-865-0587, ext. 103 or email dparilla@csms.org.