

APPLICATION FOR MEMBERSHIP

Connecticut State Medical Society

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

Litchfield County Medical Association

POB 416, Torrington, CT 06790 (860) 482-3310

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

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

**LITCHFIELD COUNTY MEDICAL ASSOCIATION
CONNECTICUT STATE MEDICAL SOCIETY
DUES SCHEDULE**

	<u>FULL</u>	<u>1st Year PRACTICE*</u> New Applicant	<u>2nd Year PRACTICE*</u> New Applicant
LCMA	\$ 200.00	\$ 100.00	\$ 200.00
CSMS	<u>620.00</u>	<u>310.00</u>	<u>620.00</u>
	\$ 820.00	\$ 410.00	\$ 820.00
AMA	<u>\$ 420.00</u>	<u>\$ 210.00</u>	<u>\$ 315.00</u>
	\$1240.00	\$ 620.00	\$ 1135.00

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

PRORATED DUES SCHEDULE

Applications for membership received:

On or before June 30 th :	Full dues amount
July 1 st through October 31 st :	One-half dues amount
On or After Nov. 1 st :	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-LCMA, 127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473.

Indicate Allocation of Dues

LCMA	\$ _____
CSMS	\$ _____
AMA	\$ _____
TOTAL	\$ _____

Name

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