

APPLICATION FOR MEMBERSHIP

Connecticut State Medical Society

127 Washington Avenue, East Bldg, Lower Level, North Haven, CT 06473 • 203-865-0587 • Fax 203-865-4997

Hartford County Medical Association

250 Wolcott Road, Wolcott, CT 06716 • 860-441-6142

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST (INDICATE MD OR DO)

PRIMARY OFFICE

NAME OF PRACTICE: \_\_\_\_\_

STREET ADDRESS CITY STATE ZIP

OFFICE TELEPHONE: \_\_\_\_\_ OFFICE FAX: \_\_\_\_\_

NAME OF PRACTICE/OFFICE MANAGER: \_\_\_\_\_ PHONE & EXT: \_\_\_\_\_

EMAIL ADDRESS OF PRACTICE/OFFICE MANAGER: \_\_\_\_\_

HOME: \_\_\_\_\_  
STREET ADDRESS CITY STATE ZIP

PREFERRED MAILING ADDRESS: \_\_\_\_\_ OFFICE \_\_\_\_\_ HOME

EMAIL: \_\_\_\_\_ WEBSITE: \_\_\_\_\_

CT MEDICAL LICENSE #: \_\_\_\_\_ DATE RECEIVED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ NATIONAL PROVIDER ID#: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_ SUBSPECIALTY: \_\_\_\_\_

ABMS BOARD CERTIFIED: \_\_\_\_\_ YES \_\_\_\_\_ NO BOARD: \_\_\_\_\_ DATE REC'D: \_\_\_\_\_

OTHER SPECIALTY TRAINING: \_\_\_\_\_

SPECIAL SERVICES (i.e., homeopathy, acupuncture, laser, etc.): \_\_\_\_\_

MEDICAL SCHOOL: \_\_\_\_\_  
NAME CITY STATE / COUNTRY

DATE OF GRADUATION: \_\_\_\_\_

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

HOSPITAL LOCATION SERVICE DATES

INTERNSHIP: \_\_\_\_\_

RESIDENCY:

PG1: \_\_\_\_\_

PG2: \_\_\_\_\_

PG3: \_\_\_\_\_

PG4: \_\_\_\_\_

FELLOWSHIP: \_\_\_\_\_

**TYPE OF PRACTICE:** \_\_\_\_\_ SOLO \_\_\_\_\_ PARTNERSHIP (2 PHYSICIANS) \_\_\_\_\_ GROUP (3 OR MORE PHYSICIANS)  
\_\_\_\_\_ OTHER (PLEASE SPECIFY) \_\_\_\_\_

**WORK SETTING:** \_\_\_\_\_ PRIVATE PRACTICE \_\_\_\_\_ HOSPITAL \_\_\_\_\_ OTHER \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE DATE

**DUES SCHEDULE**

(Please circle your category and allocation of dues)

	FULL	1ST YEAR PRACTICE New Applicant	2ND YEAR PRACTICE New Applicant
HCMS	\$ 390.00	\$ 195.00	\$ 390.00
CSMS	<u>620.00</u>	<u>310.00</u>	<u>620.00</u>
	\$ 1010.00	\$ 505.00	\$ 1010.00
AMA	\$ <u>420.00</u>	\$ <u>210.00</u>	\$ <u>315.00</u>
	\$ 1430.00	\$ 715.00	\$ 1325.00

**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 November 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**, with this completed application to CSMS, 127 Washington Avenue, East Bldg, Lower Level, North Haven, CT 06473

**Please circle allocation of dues in the chart above.**

Questions: Please call 203-865-0587, ext 111, or email [dtyrrell@csms.org](mailto:dtyrrell@csms.org).