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

Litchfield County Medical Association

P.O. Box 416, Torrington, CT 06790 • 860-482-3310

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:

PGI: _____

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
LCMS	**$ 200.00**	**$ 100.00**	**$ 200.00**
CSMS	**620.00**	**310.00**	**620.00**
	$ 820.00	**$ 410.00**	**$ 820.00**
AMA	**$ 420.00**	**$ 210.00**	**$ 315.00**
	$1240.00	**$ 620.00**	**$1135.00**

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 wil 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, ot email dtyrrell@csms.org.