

# APPLICATION FOR MEMBERSHIP

## Connecticut State Medical Society

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

## New London County Medical Association

One Regency Drive, Bloomfield, CT 06002 (860) 447-9408

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
<b>INTERNSHIP:</b>	_____			

**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.

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SIGNATURE

DATE

**PLEASE TURN OVER FOR DUES SCHEDULE**

**NEW LONDON COUNTY MEDICAL ASSOCIATION  
CONNECTICUT STATE MEDICAL SOCIETY  
DUES SCHEDULE**

	<u>FULL</u>	<u>1<sup>st</sup> Year PRACTICE*</u> New Applicant	<u>2<sup>nd</sup> Year PRACTICE*</u> New Applicant
NLCMA	\$ 250.00	\$ 125.00	\$ 250.00
CSMS	<u>620.00</u>	<u>310.00</u>	<u>620.00</u>
	\$ 870.00	\$ 435.00	\$ 870.00
AMA	\$ <u>420.00</u>	\$ <u>210.00</u>	\$ <u>315.00</u>
	\$1290.00	\$ 645.00	\$ 1185.00

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

**PRORATED DUES SCHEDULE**

Applications for membership received:

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

**Indicate Allocation of Dues**

NLCMA	\$ _____
CSMS	\$ _____
AMA	\$ _____
<b>TOTAL</b>	\$ _____

\_\_\_\_\_  
Name

Questions: Please call 203-865-0587, ext. 103 or email [dparilla@csms.org](mailto:dparilla@csms.org).