APPLICATION FOR MEDICAL SOCIETY ASSOCIATE MEMBERSHIP

DIRECTIONS: Please complete all parts of this application. Payment for the appropriate amount of dues must accompany your application along with a photo for the directory and website. For any questions, please contact 719-281-6073 or cheryl.law@pueblocms.org. Our members are highly valued. Thank you for applying for membership.

Associate Membership Dues: $150.00 per year upon approval of your application by the Board of Directors.

Name: _____ _____ _____ _____
Last First Middle Degree

Birth Date: _____ Gender: ☐ Male ☐ Female

Primary Office:

Name: _____

Address: _____ _____ _____ _____ _____
Street Suite City State Zip

Phone: _____ Fax: _____

E-Mail: _____ Web site: _____

Personal Information:

Address: _____ _____ _____ _____ _____
Street Suite City State Zip

Phone: _____ E-Mail: _____

Spouse Name: _____ Mr.___ Ms.___Mrs.___ Dr.___

Preferred Mailing Address: ☐ Office ☐ Home / Preferred Email Address: ☐ Office ☐ Home

Specialty: _____ Board Certification: _____
Original Date/Recertification Date

Medical School:

_____ _____ _____
Full Name of Institution Type of Training/Specialty Began Mo/Yr – Graduated Mo/Yr

Residency:

_____ _____ _____
Full Name of Institution Type of Training/Specialty Began Mo/Yr – Graduated Mo/Yr

Fellowship/Preceptorship:

Full Name of Institution	Type of Training/Specialty	Began Mo/Yr – Graduated Mo/Yr

Other Graduate Degrees:

Full Name of Institution	Type of Training/Specialty	Began Mo/Yr – Graduated Mo/Yr

Are any of the following conditions currently in process or have they occurred since your last application, either on a *__voluntary__ or i__nvoluntary__ basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons?

Membership on any hospital/medical staff?	☐ Yes	☐ No
Medical license in any state?	☐ Yes	☐ No
Professional society membership?	☐ Yes	☐ No

Are there any judicial or regulatory actions pending which could result in denial, restrictions, suspension, or revocation of your license to practice medicine? ☐ Yes ☐ No

(***All "Yes" answers to the following require full explanation on a separate page***)

If elected to membership, I agree to conduct myself professionally and personally according to the AMA Principles of Medical Ethics and to be governed and bound by the Constitution and Bylaws of the society(ies) for which I am applying. Furthermore, I hereby affirm that I have no physical, mental, or emotional condition, which would impair my ability to provide an acceptable standard of medical care. I understand that submission of false or fraudulent information many result in denial of membership or expulsion from the society(ies).

I hereby release, and hold harmless from any liability or loss, the society(ies) for which I am applying, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any and all individuals, organizations, and agencies or their authorized representatives from any liability concerning information provided about my professional competence, ethical conduct, character, and other qualifications for membership.

Applicant's Signature:_____ Date: _____

Please email application to contactus@pueblocountyms.org or postal mail to:
1925 E. Orman Ave., Ste. A448, Pueblo, CO 81004

Once your application is approved, you will receive a dues receipt via your preferred email address.
Please attach your professional photo for use in our pictorial directory and Web site.

FOR OFFICE USE ONLY:

The Board of Directors of the Society having fully considered this application and appropriate supporting documents recommends the following actions:

Accept ____ Reject ____ Signature: _____ Date:_____
Chief Executive Officer