APPLICATION FOR MEDICAL SOCIETY MEMBERSHIP

For Physicians in Internship / Residency / Fellowship / Preceptorship Program

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.

I AM APPLYING FOR:

Local Component: Pueblo - $25.00 (required)   State: CMS - no charge   National: AMA- $45.00

Name:____________________ Degree:________ Male: Female:

Mailing Address:____________________

Mobile Phone:____________________ Email:____________________

Date of Birth:____________________ Spouse:____________________

I have been accepted in to the program: Internship Residency Fellowship Preceptorship at:

Program Name and Hospital Address:____________________

Program Department Phone:____________________ Expected Date Training to be Completed:________

Program Email Address:____________________

Colorado License Number:____________________ Date Issued:____________________

Foreign Language(s) Spoken:____________________ ECFMG# (applicable to Medical Schools Outside of USA):________

Specialty:____________________

In the CMS and/or PCMS Directory and/or Web site, list contact information for: Hospital and/or Home

MEDICAL SCHOOL:

____

Full Name of Institution/City/State   Degree   Grad Mo / Yr

INTERNSHIP:

____

Full Name of Institution/City/State   Specialty   Began Mo/Yr - Ended Mo/Yr

RESIDENCY:

____

Full Name of Institution/City/State   Specialty   Began Mo/Yr - Ended Mo/Yr

FELLOWSHIP/PRECEPTORSHIP (circle one):

____

Full Name of Institution/City/State | Specialty | Began Mo/Yr - Ended Mo/Yr

OTHER GRADUATE DEGREE(S):

____

Full Name of Institution/City/State | Degree | Began Mo/Yr - Ended Mo/Yr

If you answer yes to any of the following questions, please explain on a separate page and attach to this application:

1. Have you ever been convicted of a felony? Yes No
2. Have your hospital medical staff privileges ever been refused, revoke, suspended or reduced? Yes No
3. Has your license to practice medicine ever been denied, restricted, suspended or revoked? Yes No
4. Are there any judicial or regulatory actions pending which could result in denial, restriction, suspension, or revocation of your license to practice medicine? Yes No
5. Have you ever been expelled from or denied membership in a state or local medical society? Yes No
6. Is there any pending review or disciplinary action with a state or local medical society regarding your membership? Yes No

Have you previously been a member of Colorado Medical Society? Yes No

If yes, when? From To

If you are a member of or have applied for membership to any other component medical society, please list the name below:

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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

Recommended By:______________________________________ ____________________

Program Director's Signature (required) Name Typed or Printed