



# Charlotte County Medical Society Membership Application

Please Return Application to us via Fax, Email or Mail:

The Charlotte County Medical Society

PO Box 494144

Port Charlotte, Florida 33949

Email: [director@ccmsdoctors.com](mailto:director@ccmsdoctors.com)

Office: (941) 625-6229 Cell: 941-391-1179 Fax: 1-888-739-7861

## PERSONAL INFORMATION (please print or type)

\_\_\_\_\_  MD  DO  
Last Name First Middle

AMA Medical Education # \_\_\_\_\_ FL Medical License # \_\_\_\_\_

Social Security # \_\_\_\_\_ DEA # \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace \_\_\_\_\_

Spouse's Full Name: \_\_\_\_\_

Practice/Group Name: \_\_\_\_\_

Practice/Group Administrator: \_\_\_\_\_

Practice Type:  Solo  Group  Employed  Government Based  Academic  Other

Primary Specialty: \_\_\_\_\_ Secondary Specialty: \_\_\_\_\_

Name of CCMS Member that recruited you, if applicable: \_\_\_\_\_

## PERSONAL INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at  HOME  OFFICE PLEASE NOTE YOUR INFORMATION WILL NEVER BE SOLD OR SHARED.

Office Address Home Address

Office City/State/Zip Home City/State/Zip

Office Phone Home Phone

Office FAX Home FAX

Email Address Website Address

## EDUCATION

Medical School: \_\_\_\_\_

Address: \_\_\_\_\_

Degree: \_\_\_\_\_ Date: \_\_\_\_\_

ECFMG Certificate # \_\_\_\_\_ Date of Certificate: \_\_\_\_\_

Internship: \_\_\_\_\_ Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Residency: \_\_\_\_\_ Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Fellowship: \_\_\_\_\_ Dates: \_\_\_\_\_

Address: \_\_\_\_\_

**BOARD CERTIFICATIONS**

1. Name of Board: \_\_\_\_\_

Certified in \_\_\_\_\_ Date: \_\_\_\_\_

2. Name of Board: \_\_\_\_\_

Certified in \_\_\_\_\_ Date: \_\_\_\_\_

**HOSPITAL AFFILIATIONS**

1. Hospital \_\_\_\_\_

Address: \_\_\_\_\_ Privileges Held: \_\_\_\_\_

2. Hospital \_\_\_\_\_ Privileges Held: \_\_\_\_\_

Address: \_\_\_\_\_

3. Hospital: \_\_\_\_\_ Privileges Held: \_\_\_\_\_

**PROFESSIONAL AFFILIATIONS**

Name of Society: \_\_\_\_\_ Date of Membership: \_\_\_\_\_

Name of Society: \_\_\_\_\_ Date of Membership: \_\_\_\_\_

**REFERENCES**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

**MEMBERSHIP APPLICATION & QUALIFICATION QUESTIONS**

Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign, and date. If you answer yes to any of these questions, please attach full information.

**Yes No**

Have you ever been convicted of fraud or a felony?

Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.

Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society.

The foregoing information is true and complete.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Remittance of Membership Dues**

**\*\*Kindly remit the dues as reflected on the Charlotte County Medical Society Dues Statement form included with this application. If you should have any questions or comments, please feel free to contact this office. Thank you.**



**Please send Payment To:**  
 CCMS  
 P.O. Box 494144  
 Port Charlotte, FL 33949

**To:**

*FOR ANY QUESTIONS PLEASE CONTACT DANIELLE: 941-625-6229*

2021 MEMBERSHIP DUES STATEMENT	AMOUNT
<p><b>Charlotte County Medical Society Annual Dues</b> (<i>includes participation in the following</i>):                      (18-20 CME Credits &amp; Dinners, Blue Cross/Blue Shield Health Insurance Program, OptaComp - FL Worker's Comp Insurance Dividend Program, Free listing in annual printed Physicians Directory publication, Free Legal Advice Discounted Contract Review and Negotiation (FMA), Representation &amp; Advocacy for Physicians' in the Legislature, Physician Networking Events, Free Notary Service, Discount on CE Broker, Patient Referral Service &amp; Physician Information Service (Public Service)).</p> <p><b>*CCMS Foundation:</b> (used to fund medical missions, staff Virginia B. Andes Clinic, grants for Hope Clinic) (Optional): \$50.00</p>	<p><b>\$355.00</b></p>
<p><b>Your annual dues are immeasurable. This is <u>YOUR</u> professional association.                      We <i>NEED</i> your continued support.</b></p> <p><b>Because of your membership, we are <i>united</i> and growing <i>stronger</i>.</b></p>	
<p><b>KINDLY REMIT YOUR PAYMENT TODAY!</b>                      Charlotte CMS dues are due upon receipt of invoice.</p>	
<p><b>Membership is now more important than ever!</b></p>	
	<p>Total: _____</p>

**MEMBERSHIP PAYMENT OPTIONS**

**PHYSICIAN:** \_\_\_\_\_ **TOTAL AMOUNT REMITTED: \$** \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

- Make your check payable to: **Charlotte County Medical Society** OR
- Credit Card Payment:  **Discover**  **MasterCard**  **Visa**  **AMEX (FOUR DIGIT CODE ON FRONT)** \_\_\_\_\_

**Card#** \_\_\_\_\_ **3 Digit Code (back of card)** \_\_\_\_\_ **Exp. Date** \_\_\_\_\_

**Zip Code for the mailing address of credit card bill** \_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_

If paying by credit card, you may call our office 941-625-6229 and pay by phone or fax this invoice to our secured fax at 1-888-739-