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
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

2019 MEMBERSHIP DUES STATEMENT	**AMOUNT**
Charlotte County Medical Society Annual Dues (*includes participation in the following):* (18-20 CME Credits & 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 & Advocacy for Physicians' in the Legislature, Physician Networking Events, Free Notary Service, Discount on CE Broker, Patient Referral Service & Physician Information Service (Public Service)).	**$355.00**
***CCMS Foundation:** **(used to fund medical missions, staff Virginia B. Andes Clinic, grants for Hope Clinic) (Optional): $50.00**	

Your annual dues are immeasurable. This is YOUR professional association.
We *NEED* your continued support.

Because of your membership, we are *united* and growing *stronger*.

KINDLY REMIT YOUR PAYMENT TODAY!

Charlotte CMS dues are due upon receipt of invoice.

MEMBERSHIP PAYMENT OPTIONS

Membership is now more important than ever!

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 1-888-739-7861.