Print Form | Submit by Email

2019

Peoria Medical Society

Application For Membership and Website Physician Info Service

Physician Member referred by: _____ Date of Application _____

Personal Information

Please check one: ☐ Physician ☐ Resident ☐ Student ☐ MD ☐ DO

Marital Status _____

_____ _____ _____ ☐ Male ☐ Female

Last Name **First Name** **M. I.**

Spouses Name _____

_____ _____

Birthdate **Place of Birth (City/State/Zip/Country)**

My spouse is interested in receiving information about the Peoria Medical Society Alliance: ☐ Yes ☐ No

Home Address in Peoria Area: _____ _____ _____

Street City/State Zip

Telephone _____ Fax _____ Home email _____

If you are a student, please complete: ME# if known _____

Medical School Name _____ Graduation Year _____

Professional Information

Peoria Office/Group Name: _____

Peoria Office Address: _____ _____ _____

Street City/State Zip

_____ _____ _____ _____

Office Email Address Office Website URL Telephone Fax

Specialty: _____ Specializing within your specialty: _____

Office Manager's Name: _____ Languages: _____

Accepting New Patients: ☐ Yes ☐ No

Date Beginning Practice in Peoria: _____ Beginning Practice for the First Time? ☐ Yes ☐ No

If no, what year did you begin practice: _____

Most Recent Practice at: _____ From _____ To _____

Address/City/State

Most Recent Medical Society Membership: _____ From _____ To _____

Address/City/State

Are you currently a member of AMA? ☐ Yes ☐ No ME Number # _____

(Please continue on next page)

Education and Training

Medical School: | Degree | City/State | From | To

Internship/Residency: | Degree | City/State | From | To

Internship/Residency: | Degree | City/State | From | To

Fellowship Training: | Degree | City/State | From | To

American Boards and License Number

Specialty Board Name | Date of Certification | Expires

Specialty Board Name | Date of Certification | Expires

Illinois License Number | Expiration Date:

Qualification Questions and Signature

If you answer YES to any of these questions, please explain on a separate sheet.

1. Have you ever been denied membership or been subject to disciplinary action in any medical association? ☐ Yes ☐ No

2. Have you ever been denied a medical license, or has your medical license been suspended or revoked in any state? ☐ Yes ☐ No

3. Have you ever been convicted of fraud or a felony? ☐ Yes ☐ No

I am aware that 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(ies).

If granted membership, I agree to support the Constitution and Bylaws of the Peoria Medical Society

Signature | Date

Membership Dues

***Peoria Medical Society**

Regular Physician Dues: ☐ $415

1st Year in Practice Dues: ☐ Free

2nd Year in Practice Dues: ☐ $100

3rd Year in Practice Dues: ☐ $200

Student/Resident Dues: ☐ Free

Payment Options

☐ **Check enclosed** payable to Peoria Medical Society:

☐ **Please bill me** according to my choices.

Optional Scholarship Suggested Donation ☐ $25

Office Use Only

I hereby attest that the above named applicant was duly elected to membership in the Peoria Medical Society at a meeting held on the _____ day of _____, 20_____. _____

Signed

Peoria Medical Society - 809 W Detweiller Drive - Suite 817 Peoria, IL 61615 - Phone: 309/692-1192 - Fax: 309/692-0492