

Collier County Medical Society Membership Enrollment Form – Active & Associate

Member Dues (select all that apply):

- 1st time member \$300
- CCMS PAC \$100 (optional)



Return form to CCMS:
 88 12th St N, #200, Naples, FL 34102
 Ph (239) 435-7727 Fax (239) 435-7790
 info@ccmsonline.org

Please send a color photo in an attached jpeg file to info@ccmsonline.org for our annual directory

PERSONAL INFORMATION (please print or type)

Last Name _____ First _____ Middle _____ MD DO
 Gender: Male Female Date of Birth: ___/___/___ Spouse Full Name: * _____
 Practice Name: _____ Solo Group Employed Concierge Practicing in Collier since _____
 I am applying for: Active Membership Associate Membership (For members of more than one county society, and primary membership is not CCMS)
 Primary Specialty: _____ Secondary Specialty: _____

*Spouses may contact the CCMS Alliance at www.ccmsalliance.info for membership information.

EDUCATION

Institution / Location

Medical School: _____ Date: _____
 Internship: _____ Date: _____
 Residency: _____ Date: _____
 Fellowship: _____ Date: _____

BOARD CERTIFICATIONS (recognized by Florida Board of Medicine):

Board: _____ certified in: _____ Date: _____
 Board: _____ certified in: _____ Date: _____

HOSPITAL AFFILIATIONS:

Attach a letter of reference from a physician. Reference Name: _____ Fax: _____

Reference Phone: _____ Email: _____

Reference Address: _____

OFFICE ADDRESS

HOME ADDRESS (Home / email confidential, for CCMS business use only)

Office Address _____		Home Address _____	
Office City/State/Zip _____		Home City/State/Zip _____	
Office Phone _____	Office Fax _____	Home/Cell Phone _____	
Office Website _____		Email _____	
Office Manager _____	Office Mgr Ph _____	Office Mgr Email _____	

Billing preference: Home Ofc Other _____ Member mailings preference: Home Ofc

MEMBERSHIP 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 answer 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 form will be verified.

I hereby authorize other organizations having information relating to this form, including governmental and regulatory entities, to release any and all such information.

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

The foregoing information is true and complete.

Signature _____

Date _____

PAYMENT – Please do not email unencrypted credit card information

Total Payment \$ _____ Check enclosed Visa MasterCard AMEX Card #: _____

Name on Card: _____ Signature: _____

Expiration Date: _____ Billing Address: _____

The endorsement, deposit or negotiation of payment does not constitute admission into or acceptance of membership by CCMS. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. If membership enrollment is not completed, CCMS will refund the amount sent. Tax Deduction information: The Revenue Reconciliation Act of 1993 states that association dues used for lobbying activities are not deductible as a business expense. While Association dues are not tax deductible as charitable contributions for federal income tax purposes, they may be tax deductible under other provisions of the Internal Revenue Code. Contributions to CCMS PAC are not tax deductible.