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)

_____ ☐ MD ☐ DO

Last Name First Middle

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: _____

Please provide the name of a physician reference. Reference Name: _____

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.