SARASOTA COUNTY MEDICAL SOCIETY

4153 Clark Road
Sarasota, FL 34233
941.966.3134
Fax 941.554.8845
info@sarasotacountymedical.com

MEMBERSHIP APPLICATION

APPLICANT INFORMATION*			
Last Name	First	M.I.	Date
Current Professional Practice Name		Office Telephone	
Office Address		Office Fax	
City	State	ZIP	
Primary Specialty		Subspecialty	
Practice Manager	Prac Mgr E-mail	Board Certified	
Home Street Address		Date of Birth	
City	State	ZIP	
Phone	Physician Personal E-mail Address*		
Name of Spouse (if applicable)	Additional languages spoken fluently		
Referred by	Physician Cell Phone*		

*The information provided will be used only for its intended purpose. We will only share your information with other entities within the Sarasota County Medical Society.

APPLICATION MEMBERSHIP & QUALIFICATION QUESTIONS

Members agree to abide by the AMA principle of Ethics. 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 a complete explanation on a separate sheet and the relevant document.

YES	NO	
☐	☐	Have you ever been convicted of fraud or felony?
☐	☐	Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving termination, revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.
☐	☐	Have you ever been the subject of any disciplinary action or investigation by any hospital, clinic, healthcare facility, or professional medical associations or societies?

I am aware that the following 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 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 Sarasota County Medical Society. **SCMS, in their sole discretion and upon the majority approval of the Board, reserves the right to terminate membership privileges to any member, with or without cause.**

The foregoing information is true and complete. I further understand that by providing the fax number/email above, I hereby consent to receive communication sent by the Sarasota County Medical Society. (SCMS)

_____ *Date*_____

Signature

The endorsement or negotiation of applicant's check does not constitute admission or acceptance of membership by the SCMS until applicant is approved by Board of Censors. Applicants who are not admitted into membership will be refunded their dues payment.

MEMBERSHIP PAYMENT OPTIONS

Payment for: SCMS Annual Dues - $395.00

☐ Check made payable to: **Sarasota County Medical Society** ☐ Credit Card Payment: ☐**Discover** ☐**MasterCard** ☐**Visa**

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

Mailing address of credit card bill_____

Authorized Signature _____

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