

**MEMBERSHIP APPLICATION**

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

\*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.

<b>APPLICATION MEMBERSHIP &amp; QUALIFICATION QUESTIONS</b>		
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.		
<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>	Have you ever been convicted of fraud or felony?
<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	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** \_\_\_\_\_