Seminole County Medical Society Membership Application

Return Application and Membership Dues to:

Seminole County Medical Society, 1215 E. Robinson St., Orlando, FL 32801

407-804-9535 | Fax 407-804-9445
scms@scmsociety.com www.scmsociety.com

PERSONAL INFORMATION (please print or type)

Date:

______________________ ____ ☐ MD ☐ DO
Last Name First Middle

AMA/AOA Medical Education #: ________________________________

FL Medical License #: ________________________________

Sex: ☐ Male ☐ Female Date of Birth: ____/ ______ / _______ Place of Birth: ____________________

Spouse's Full Name: ________________________________

Practice/Group Name: ________________________________

Website Address: ____________________ Office Manager Name & Email:____________________

Practice Type: ☐ Solo ☐ Group ☐ Employed ☐ Government Based ☐ Academic ☐ Other

Primary Specialty: ________________________________

Secondary Specialty: ________________________________

Name of FMA/SCMS Member that recruited you: ________________________________

MAILING INFORMATION

Please provide both addresses. Do you prefer to receive mail at ☐ HOME ☐ OFFICE

Office Address | Home Address

Office City/State/Zip | Home City/State/Zip

Office Phone | Home Phone

Office FAX | Home FAX

Email Address | SPOUSE Email Address

EDUCATION

Medical School: ________________________________ Degree: ______________

City, State, Country: ________________________________ Date: ______________

Residency/Fellowship: ________________________________ Date Completed:______________

City, State, Country: ________________________________

BOARD CERTIFICATIONS

1. Name of Board: ____

Certified in ____ Date: ____________

2. Name of Board: ____

Certified in ____ Date: ____________

HOSPITAL AFFILIATIONS

1. Hospital (Primary) ____

City: ____

2. Hospital (Secondary) ____

City: ____

MEMBERSHIP APPLICATION & QUALIFICATION QUESTIONS

Members abide by the American Medical Association Principles of Medical Ethics and bylaws. 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 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 disciplinary action by any medical society or hospital medical staff?

I am aware that the 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).

The foregoing information is true and complete.

____

Signature Date

PAY BY CHECK OR CREDIT CARD

☐ Check enclosed for $ ______________ payable to SCMS. Check # ____________ Date: ____________

☐ Charge to my credit card ☐ Visa ☐ Master Card Amount: $ ______________

Account #: ____ Exp. Date: ______________

Three Digit Security Code (found near signature on back of card): ____________

Name on Card: ______________________________ Signature: ______________________________

The endorsement, deposit or negotiation of an applicant's payment does not constitute admission into or acceptance of membership by the CMS or FMA. Monies received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a check refunding the amount sent in.

Thank you!

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