2016 Membership Application
Kane County Medical Society

*Required Information

Applicant Information

Check one: ☐ Physician ☐1st year ☐2nd Year ☐3rd Year ☐4th Year ☐ Resident ☐ Student *Degree ☐MD ☐DO *Gender ☐M ☐F

*Last Name (as shown on medical license) ______ *First ______ * Middle initial ______ Additional Credentials ______

Spouse's Last Name (if applicable) ______ Spouse's First Name ______

*Home Address ______ *City ______ * State ______ *Zip ______

Cell Phone ______ Text ☐ Yes ☐ No Home E-mail ______ * Birth Date (mm/dd/yy) ______

*Place of Birth ______ Medical Education Number (if known) ______

*Medical School Name ______ *City ______ *Graduation Year ______ Maiden Name (if applicable) ______

Professional Information

*Primary State of Licensure ______ *State License Number ______ Other State Licenses ______ *Primary Specialty ______ * Board Certified ☐Yes ☐No ☐Eligible

*Practice Name ______ *Practice Manager Name ______ *Office Manager E-mail ______

*Office Address (primary) ______ *City ______ *State ______ *Zip ______

*Office Telephone ______ *Office Fax ______ *Doctor's Office E-mail ______

*Beginning Year of Practice (Date) ______ *Hospital Affiliation(s) ______

*Preferred Email Address: ☐ Office ☐Home *Preferred Mailing Address: ☐Office ☐ Home

Permission to send: Due to the federal communication regulations, it is necessary for KCMS to obtain consent to distribute information via fax and e-mail. By checking the boxes and providing your fax and email address, you agree to receive emails and facsimiles, including meeting and seminar information, manager programs and events and services offered by the Kane County Medical Society.

Membership Application and Qualification Questions

Members abide by the ISMS Code of Medical Ethics and bylaws of the Society. 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		
☐	☐	1.	Have you been convicted of fraud or a felony?
☐	☐	2.	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 imposed sanctions or conditions?
☐	☐	3.	Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that 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 ______

Kane County Medical Society

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