Kane County Medical Society
473 Dunham Road, Suite 218
St. Charles, IL 60174   Ph: 630-584-6129   Fx: 630-584-6703

*Required Information

Check one: ☐ Physician ☐ 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 ____

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

*Medical School Name ____ *City ____ *Graduation Year ____

*IL State License Number ____ *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, promotional materials about any of our services or products, benefits, 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.

1. Have you been convicted of fraud or a felony? YES NO
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? YES NO
3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff? YES NO

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 ____

Payment Information

___ Annual payment ($325.00)

Pay by Credit Card:

Name on Card: ____

Card Billing Address: ____

____

Card #: ____

Exp. ____ V-Code ____

RECEIPT OF PAYMENT SENT UPON REQUEST

Email Receipt to: ____

Make checks payable to Kane County Medical Society

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