MANATEE COUNTY MEDICAL SOCIETY
First to fight for your profession

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Membership Application

APPLICANT INFORMATION			Today's Date:
Last Name:	First:	M.I.:	ME or OS #:
Current Professional Practice Name:			Office Phone:
Office Address:			Office Fax:
City:	State:		Zip:
Primary Specialty:	Subspecialty:		Board Certification:
Practice Mgr.:	Prac. Mgr. Ph. & Email:		
Home Address:			Date of Birth:
City:	State:		Zip:
Physician Cell Phone*:	Physician Personal Email*:		Referred by:
Spouse Name:	Languages Spoken:		NPI #:

*The information provided will be used only for its intended purpose. Manatee County Medical Society will share your information only within its membership.

Application Membership & Qualification Questions

Members agree to abide by the AMA principles 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 relevant documentation.

YES □	NO □	Have you ever been convicted of fraud or felony?
YES □	NO □	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.
YES □	NO □	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 organization having information relating to this application, including governmental and regulatory entities, to release and all information.

I understand that any false or misleading statements mad on my application may be grounds for denial of membership or probation or censure by or suspension or expulsion form Manatee County Medical Society. **MCMS, 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 communications sent by Manatee County Medical Society (MCMS).

_____ _____

Signature: *Date:*

The endorsement or negation of applicants check does not constitute admission or acceptance of membership by MCMS until applicant is approved by the Board of Governors. Applicants who are not admitted into membership will be refunded their dues payment.

Membership Payment Options

□ Check made payable to: Manatee County Medical Society □ Credit Card Payment: □ VISA □ Mastercard □ AMEX □ Discover

Card #: _____ 3 digit code (back of card) _____ Exp. Date: _____

Mailing address of credit card statement: _____

Authorized Signature: _____