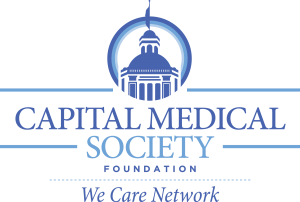
   
  
**Capital Medical Society**

**Membership Application**

###### Please Return Application to: Capital Medical Society, 1204 Miccosukee Road, Tallahassee, FL 32308

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|  | |  |  | | --- | --- | | **Question** | **Answer** | | Full Name |  | | FL Medical License #: |  | | NPI#: |  | | Sex: | 🞏 Male 🞏 Female | | Date of Birth/Place of Birth: |  | | Spouse's Full Name: |  | | Practice/Group Name: |  | | Practice/Group Administrator: |  | | Practice/Group Administrator email address: |  | | Practice Type: | 🞏 Solo 🞏 Employed 🞏 Medical Student  🞏 Group 🞏 Government Based 🞏 Academic 🞏 Other | | Primary Specialty: |  | | Secondary Specialty: |  | | Name of CMS Member that recruited you: |  | | Please provide both addresses for our personal use. Do you prefer to receive mail at: | 🞏 Home 🞏 Office | | Office Address: |  | | Office City/State/Zip: |  | | Office Phone: |  | | Office FAX: |  | | Home Address: |  | | Home City/State/Zip: |  | | Home Phone: |  | | Cell Phone: |  | | Email Address: |  | | Medical School/Degree/Date: |  | | Internship/Date: |  | | Residency/Date: |  | | Fellowship/Date: |  | | 1. Name of Board: |  | | Certified in, on (date): |  | | 2. Name of Board: |  | | Certified in, on (date): |  | | 1. Hospital (Primary) |  | | 2. Hospital (Secondary) |  | | *Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations.  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.* |  | | Have you ever been convicted of a felony or fraud? | 🞏 Yes 🞏 No | | 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. | 🞏 Yes 🞏 No | | Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff? | 🞏 Yes 🞏 No | | *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 | |  |

Option to fill out on our website: https://capmed.org/become-a-member/



Currently 315 of your fellow physicians in Tallahassee volunteer in this program, donating specialty care to low-income, uninsured patients in great need.  In addition, 49 dentists volunteer to provide dental care.

Medical social workers, employed by the Capital Medical Society Foundation, carefully screen patients for eligibility.  These medical social workers provide case management and refer patients on a fair rotation basis to the different specialists.  Once you finish providing treatment to a *We Care* patient, the patient is referred back to their primary care home.  They do not become your permanent responsibility.  Patients are very grateful for the medical care you provide, and you will find this a rewarding experience.

When you join the *We Care Network*, you are joining an impressive, award-winning program.  All the medical providers in town participate:  from both hospitals, to labs, imaging centers, durable medical equipment to home health.

And, as a physician volunteer with the *We Care Network*, you are eligible for up to 5 CME credits per biennium.

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| 🞏 Yes, I will participate in the **CMS Foundation We Care Network.** | 🞏 I cannot participate in the **CMS Foundation We Care Network** at this time; please contact me again. |
| I will agree to see | \_\_\_\_\_\_\_\_\_\_\_ patients 🞏 per month or 🞏 per year |
| I want a Sovereign Immunity Contract that will protect me as a We Care Volunteer. | 🞏 Yes 🞏 No |
| Who do we contact in your office to schedule We Care Patients (Name): |  |
| Phone Number: |  |
| Signature: |  |
| Date: |  |
| Full Name: |  |