

# Clark County Medical Society

## Membership Application



Application Date:

Membership Type/Fees:  MD/DO \$390  
 PA \$150  
 Resident \$ 50

Make Checks Payable To:  
**CCMS**  
 (no credit cards)

### Section I: To Be Completed by ALL Applicants

Name:  Last  First  MI  Title:  MD  
 DO  
 PA

Birth Date:  Birth Place:  Gender:  Male  
 Female

Practice Name:

Office Address:  Street  City  State  Zip

2<sup>nd</sup> Office Address:  Street  City  State  Zip

Mailing Address:  Post Office Box  City  State  Zip

Office Phone:  Fax:  Cell:  Email:

2<sup>nd</sup> Office Phone:  Fax:  Office Manager:

Office Manager Email:  Spouse's Name:

Home Address:  Street  City  State  Zip

Nevada License #:  Year Issued:  Foreign Languages:

### Section II: To Be Completed by Physician's Assistant Applicants

Supervising Physician's Name:

### Section III: To Be Completed by Physician (MD/DO) Applicants

Medical Education:  School Name  Address/City/State/Zip  Degree Earned  Date Graduated

Internship/PGY1:  Name  Address/City/State/Zip  Date Started  Date Completed

Residency:  Name  Address/City/State/Zip  Date Started  Date Completed

Fellowship:  Name  Address/City/State/Zip  Date Started  Date Completed

Date Started Nevada Practice:  # Years in Nevada:  Accepting New Patients:  Yes  No

Primary Specialty:  ABMS Listed Specialty  Board Cert Date Secondary Specialty:  ABMS Listed Specialty  Board Cert Date

Primary Practice:  Other Board Certification:  Name of Board  Issue Date

AMA Member  Yes  No

Credentialed at the following hospitals:  Boulder City  North Vista  Southern Hills  St. Rose  Sunrise  Valley  Desert Springs  Mountain View  Spring Valley  Summerlin  UMC

**Within the last 5 years:** (For all "YES" answers, provide complete information on a separate sheet of paper)

- Have you been convicted of a felony?  Yes  No
- Has your license to practice medicine in any jurisdiction been limited, suspended or revoked?  Yes  No
- Have you been the subject of any disciplinary action by any medical society or hospital staff?  Yes  No

Please list three Physician references with complete Name and Address for each: (At least one local physician reference required)

|   |                |         |      |       |     |
|---|----------------|---------|------|-------|-----|
| 1 |                |         |      |       |     |
|   | Physician Name | Address | City | State | Zip |
| 2 |                |         |      |       |     |
|   | Physician Name | Address | City | State | Zip |
| 3 |                |         |      |       |     |
|   | Physician Name | Address | City | State | Zip |

If elected into membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the Clark County Medical Society and the Nevada State Medical Association. I hereby release, and hold harmless from any liability or loss, the Clark County Medical Society, and the Nevada State Medical Association, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability, any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership.

Applicant's Signature (no stamps)

Date

Mail completed application to: Clark County Medical Society  
2590 E. Russell Road, Las Vegas, NV 89120  
Phone: (702) 739-9989 / Fax: (702) 739-6345

Email photo (.jpg or .tiff) to: [www.ccms@lvcm.com](mailto:www.ccms@lvcm.com) An electronic photograph is required to complete the application process. Please email the photograph or visit the CCMS office to have a digital photo taken.

**FOR OFFICE USE ONLY:**

| Reference Check                       | Date(s) Sent            | Received |
|---------------------------------------|-------------------------|----------|
| 1) Reference Letter                   |                         |          |
| 2) Reference Letter                   |                         |          |
| 3) Reference Letter                   |                         |          |
| Action Items                          | Date Received/Completed |          |
| Photograph ( <i>electronic only</i> ) |                         |          |
| Payment                               |                         |          |
| AMA Profile                           |                         |          |
| ABMS Certification                    |                         |          |
| NBME License Verification             |                         |          |
| Newsletter Announcement (issue)       |                         |          |
| Approved by Board of Trustees         |                         |          |