

CARSON DOUGLAS COUNTY
MEDICAL SOCIETY

P.O. Box 2168
Carson City, Nevada 89702-2168
(775)445-8786
FAX (775) 888-3221
Shirley.Faiella@ctrh.org

APPLICATION FOR MEMBERSHIP
REGULAR () RESIDENT () AFFILIATE ()

APPLICATION DATE: _____ APPROVAL DATE: _____

(FOR CDCMS STAFF)

NAME: _____

LAST

FIRST

MIDDLE

SEX

OFFICE ADDRESS: _____

STREET

CITY, STATE, ZIP CODE

TELEPHONE #

FAX #

OFFICE MANAGER'S NAME: _____

HOME ADDRESS: _____

STREET

CITY, STATE, ZIP CODE

TELEPHONE #

FAX #

SPOUSE'S NAME: _____ LEGISLATIVE DISTRICT #: _____

MAIL ADDRESS: _____

STREET

CITY, STATE, ZIP CODE

BIRTH DATE: _____ BIRTH PLACE: _____

MEDICAL EDUCATION: _____

SCHOOL NAME (CITY & STATE)

DEGREE EARNED

DATE GRADUATED

INTERNSHIP: _____ DATE: _____

RESIDENCIES: _____ DATE: _____

_____ DATE: _____

FELLOWSHIP: _____ DATE: _____

NEVADA LICENSE NUMBER & DATE OBTAINED: _____

OTHER LICENSES: _____

STATE DTE

ACTIVE HOSPITAL APPOINTMENTS WITH DATES: _____

DATE STARTED NEVADA PRACTICE: _____

SPECIALTY: _____ SUB-SPECIALTY: _____

BOARD CERTIFICATIONS (DATE & SPECIALTY): _____

ARE YOU ACCEPTING NEW PATIENTS? () YES () NO FOR SECOND OPINIONS? () YES () NO

WHICH FOREIGN LANGUAGES DO YOU SPEAK, IF ANY?: _____

PREVIOUS MEDICAL SOCIETY MEMBERSHIPS WITH DATES: _____

ARE YOU A CURRENT AMA MEMBER? () YES () NO

TAX I.D. NUMBER: _____ MEDICARE/UPIN NUMBER: _____

WHICH INSURANCE PLANS DO YOU ACCEPT? (MEDICARE, SAMI, ETC.): _____

Within the last 5 years, have you been convicted of a felony crime?

() YES () NO If yes, please provide complete information, attach separate sheet of paper.

Within the last 5 years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?

() YES () NO If yes, please provide complete information, attach separate sheet of paper.

Within the last 5 years, have you been the subject of any disciplinary action by any medical society or hospital staff?

() YES () NO If yes, please provide complete information, attach separate sheet of paper.

Are you in recovery from alcohol or drug dependency?

() YES () NO If yes, please provide complete information, attach separate sheet of paper.

Please list in chronological order sites of previous practice beginning with present practice. Attach separate sheet if necessary.

DATES		TITLE	CITY	STATE
FROM	TO			

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 Carson Douglas County Medical Society, the Nevada State Medical Association, and the American Medical Association. I hereby release, and hold harmless from any liability or loss, the Carson Douglas 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.

Please list three **Physician** References with **complete** Name and Address for each:
(One must be a local, Carson Douglas County, physician)

1) _____

2) _____

3) _____

APPLICANT'S SIGNATURE