

CENTRAL COUNTIES MEDICAL SOCIETY

Membership Application

CATEGORIES OF MEMBERSHIP

(Please select one)

ACTIVE

ACTIVE LIMITED

AFFILIATE / PHYSICIAN'S ASSISTANT

RESIDENT

APPLICATION DATE: _____ APPROVAL DATE: _____

(FOR CNCMS STAFF)

NAME: _____
LAST FIRST MIDDLE SEX

BIRTH DATE: _____ BIRTH PLACE: _____

PRACTICE NAME: _____

OFFICE ADDRESS: _____
STREET CITY, STATE, ZIP CODE TELEPHONE # FAX # E-MAIL ADDRESS

OFFICE MANAGER'S NAME: _____

HOME ADDRESS: _____
STREET CITY, STATE, ZIP CODE TELEPHONE # FAX # E-MAIL ADDRESS

FOR CNCMS USE ONLY: Legislative District Number: _____ Assembly: _____ Senate: _____

SPOUSE'S NAME: _____

MAIL ADDRESS: _____
STREET CITY, STATE, ZIP CODE

MEDICAL EDUCATION: _____
SCHOOL NAME (CITY & STATE) DEGREE EARNED DATE GRADUATED

INTERNSHIP: _____ DATE: _____

RESIDENCY: _____ DATE: _____

FELLOWSHIP: _____ DATE: _____

NEVADA LICENSE NUMBER & DATE OBTAINED: _____

DATE STARTED NEVADA PRACTICE: _____ AMA MEMBER? () YES () NO

OTHER LICENSES: _____
STATE NUMBER DATE

PREVIOUS MEDICAL SOCIETY MEMBERSHIPS WITH DATES: _____

1. SPECIALTY: _____ BOARD CERTIFICATION DATE: _____

2. SUB-SPECIALTY: _____ BOARD CERTIFICATION DATE: _____

3. SUB-SPECIALTY _____ BOARD CERTIFICATION DATE: _____

ACTIVE HOSPITAL APPOINTMENTS WITH DATES: _____

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

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

WHICH INSURANCE PLANS DO YOU ACCEPT? _____

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 Central Counties Medical Society, the Nevada State Medical Association, and the American Medical Association. I hereby release, and hold harmless from any liability or loss, the Central Counties 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, Central Counties, physician)

- 1) _____
- 2) _____
- 3) _____

APPLICANT'S SIGNATURE

**150 S. "C" Street, Box 940 | Hawthorne, Nevada 89415
(775) 945-2415 | Fax: (775) 945-5021**