ELKO COUNTY MEDICAL SOCIETY
Membership Application

CATEGORIES OF MEMBERSHIP

(Please select one)

❒ **ACTIVE**
❒ **ACTIVE LIMITED**
❒ **AFFILIATE / PHYSICIAN'S ASSISTANT**
❒ **RESIDENT**

APPLICATION DATE: ____________________________ APPROVAL DATE: ____________________________
(FOR ECMS 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 ECMS 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 CERTIDICATION 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 seperate sheet of paper.

Within the last 5 years, has your license to practic medicine in any jurisdiction been limited, suspended or revoked?
( ) YES ( ) NO If yes, please provide complete information, attach seperate 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 seperate sheet of paper.

Are you in recovery from alcohol or drug dependency?
( ) YES ( ) NO If yes, please provide complete information, attach seperate sheet of paper.

Please list in chronological order sites of previous practice beginning with present practice. Attach seperate 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 Elko 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 Elko 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, Elko County, physician)

1) ____

2) ____

3) ____

____
APPLICANT'S SIGNATURE

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