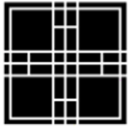

DuPage County Medical Society

MEMBERSHIP APPLICATION

DuPage County Medical Society, Illinois State Medical Society, and American Medical Association

498 Hillside Avenue, Glen Ellyn, Illinois 60137, Phone 630/858-9603, Fax 630/858-9512

Date____

Name*______________________________ Male__________ Female__________

Place of Birth______________________________ Date of Birth________________

Married___ Yes___ No___ Spouse's name______________________________

Phone________________

Residence______________________________ Fax________________

E-Mail________________

Mail address____

Office 1____

Phone________________ Fax________________ E-mail________________

Office 2________________________ Phone________________

Fax________________

Office 3________________________ Phone________________

Fax________________

Associates____

Practice Name____

Medical School____

Name Location Year Graduated

Internship____

Hospital Location Years From - To

Residency____

Hospital Location Years From - To

Residency____

Hospital Location Years From - To

Fellowship____

Hospital Location Years From - To

Illinois license issued________________________ License #________________

License(s) other ________________________ ECFMG #________________

Certified by the American Board of________________________ Date________________

* Indicate if you have been known by any other name since starting in medical school and explain.

Primary/Sub-specialty and/or special procedures____

Language(s) spoken____

Professional activities/appointments (include local, state, and AMA membership)

____

____

____

____

Hospital affiliation(s)____

Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization? Yes _____ No _____

Have your privileges at any hospital ever been suspended, denied, diminished, revoked or not renewed? Yes _____ No _____

Was your medical license in any state ever limited, suspended, revoked or voluntarily surrendered? Yes _____ No _____

Have you ever been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude? Yes _____ No _____

- -

I, ____, grant permission and consent for the DuPage County Medical Society to obtain from medical schools, hospitals of internship and residencies, as well as present hospital affiliations, information regarding degrees earned, dates of training, additional training completed, clinical skills, and ethical and moral character. I release from liability, and agree to indemnify and hold harmless, all those furnishing information, for the acts or omissions performed in good faith and without malice in connection with the gathering and exchange of information as consented to above.

A photocopy of this waiver shall be as effective as the original when so presented.

If accepted, I agree to abide by the Bylaws of the DuPage County Medical Society and the Illinois State Medical Society, and the Principles of Medical Ethics of the American Medical Association. I would like DuPage County Medical Society to send me facsimiles, including meeting and/or seminar and registration forms, benefits, promotional materials, advertising and other commercial materials, so I may take full advantage of the various programs and services offered by the DuPage County Medical Society and other related entities.

I hereby affirm and represent that all statements, answers and information contained in this application are true to the best of my knowledge and belief.

(signed)____

If you joining DCMS at the suggestion of a current DCMS member, we would appreciate the opportunity to say thank you. Please indicate the DCMS Member who referred you.

____

PLEASE INCLUDE PHOTO IF AVAILABLE .
FOR OFFICE USE ONLY:

Membership (Accept/Reject) Date__________________________