



DUPAGE COUNTY MEDICAL SOCIETY

MEMBERSHIP APPLICATION

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

1131 Wheaton Oaks Court, Wheaton, Illinois 60187, Phone 630/681-2870, Fax 630/681-2875

Date _____

Name* _____ Male _____ Female _____

Place of Birth _____ Date of Birth _____

Married Yes No Spouse's name _____

Residence _____ Phone _____
 _____ 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
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Internship _____

Hospital	Location	Years From - To
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Residency _____

Hospital	Location	Years From - To
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Residency _____

Hospital	Location	Years From - To
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Fellowship _____

Hospital	Location	Years From - To
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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 _____