



2009-10 Membership Application

- Yes. I want to apply for membership. Please process my membership today. I am applying for:
 Rock Island County Medical Society and Illinois State Medical Society American Medical Association

Check one: ___Physician ___1st year ___2nd year ___3rd year ___4th year ___resident ___student

PERSONAL INFORMATION

_____	_____	_____	_____	_____
Last Name (as shown on medical license)	First	Middle	Degree(MD/DO)	Gender(M/F)
_____	_____	_____	_____	
Maiden Name (if applicable)	Spouse's Last Name	Spouse's First Name		
_____		_____		
Home Address	City/State/ Zip			
_____	_____	_____		
Home Telephone	Home E-mail	Birth Date (m/d/y)		
_____	_____	_____	_____	
Place of birth	ME # if known	State License Number/State Issued		
_____	_____	_____	_____	
Medical School Name	Location		Graduation Year	
_____	_____		_____	
Internship	Location		Graduation Year	
_____	_____		_____	
Residency	Location		Graduation Year	
_____	_____		_____	
Fellowship(s)	Location		Graduation Year	
_____	_____		_____	

PROFESSIONAL PRACTICE INFORMATION

_____	_____	_____
Primary Specialty	Board Certified?/Year	
_____	_____	
Subspecialty	Board Certified?/Year	
_____	_____	
Clinic Name	Preferred Mailing Address	<input type="checkbox"/> Office <input type="checkbox"/> Home
_____	_____	
Office Address	(____) _____	(____) _____
_____	Telephone	Fax
_____	_____	_____
City/State/Zip	Office E-mail	
_____	_____	
Hospital Affiliations	Languages Spoken Other Than English	
_____	_____	
Name of Physician(s) Who Referred You If Applicable		

MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

Members abide by the AMA Principals of Medical Ethics and the bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign and date.

If you answer yes to any of these questions, please attach full information.

Yes No

- 1. Have you ever been convicted of fraud or a felony?
- 2. Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any imposed sanctions or conditions.
- 3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society (ies).

The foregoing information is true and complete.

Signature

Date

DUES

ISMS Dues	Amount	\$550
RICMS Dues	Amount	\$395
AMA Dues (Voluntary)	Amount	\$420
IMPAC (Voluntary)	Amount	\$200
	TOTAL	\$_____

(First year in practice dues are \$110 for ISMS, \$79 for RICMS and \$210 for AMA. Second year in practice dues are \$220 for ISMS, \$158 for RICMS and \$315 for AMA. Third year in practice dues are \$330 for ISMS, \$237 for RICMS and \$420 for AMA. Fourth year in practice dues are \$440 for ISMS, \$316 for RICMS and \$420 for AMA. Please call RICMS at (563) 328-3390 for questions.)

Make your check payable to Rock Island County Medical Society, 201 West 2nd Street, Suite 604, Davenport, IA 52801 or complete the credit card information below.

Charge to credit card: Visa MasterCard Corporate Personal

Card Number: _____

Expiration: _____

Name on card: _____

Signature

Date