



SANTA CRUZ COUNTY MEDICAL SOCIETY

Application for Membership



Please type or print in ink and fill in all blanks. Additional sheets may be attached if necessary.
If you have more than one office, please list additional office addresses on a separate sheet of paper.
A California Participating Physician Application may be substituted for this membership application.

Name: (As shown on license)		Last	First	Middle	Other Name Used (if any)	
Birth date		Place of Birth		Gender	Social Security #	
Name of Corporation/Practice:			Group Affiliation:			
Primary Office: Street Address		City	ZIP	Telephone #	Fax #	
Residence: Street Address		City	ZIP	Telephone #	Fax #	
SEND MAIL TO: <input type="checkbox"/> Office <input type="checkbox"/> Home			Email address:			
California License #	Date Issued	Date Expires	NPI#	Other State Licenses (State-Date Issued)		
Has your medical license in California or any other state ever been limited, revoked, suspended, or placed on a probationary status - or is such action pending? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please provide details on a separate sheet of paper and attach to this application)						
Medical School:		Location		Degree (MD or DO)		Date
Internships:	Institution	Address		State	Dept.	Dates
Residencies:	Institution	Address		State	Dept.	Dates
Primary Specialty		Secondary Specialty			Special Interests	
American Board Certification(s)/Date(s)						
Medical Society Memberships:		Organizations/Dates				
Please select/check the Practice Arrangement/Mode of Practice that best describes your practice:						
<input type="checkbox"/> Solo/Small (1-4 phys. group/corp)	<input type="checkbox"/> Medium (5-150 phys. group/corp)	<input type="checkbox"/> Large (150-1,000 phys. group/corp)	<input type="checkbox"/> Very Large (1,000+)			
<input type="checkbox"/> Academic Practice	<input type="checkbox"/> Hospital-Based Practice	<input type="checkbox"/> Government-Employed Physician		<input type="checkbox"/> Administrative Medicine		

The undersigned agrees in case of election that membership in this Component Medical Society shall be conditional upon compliance with the Constitution & Bylaws and Principles of Medical Ethics of the AMA, the CMA and the Component Medical Society. The undersigned further agrees that he/she will recognize the authorized Officers of said Society & Associations as the proper and sole authorities to interpret any doubtful point in professional conduct and will at all times abide by and be governed by their interpretations.

I hereby affirm that the information provided on this Application for Membership, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application and/or termination of my membership should I be elected a member of said Society and Association. I understand and agree that acceptance of this application, application fees and/or dues does not constitute approval or acceptance of my membership, and grants me no rights or privileges of membership until such time as I receive notice of approval of my application and my acceptance letter.

Applicant's Signature: _____ Date: _____

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Postgraduate/ Fellowship:	Institution	Address	City/State	Dept.	Dates
Specialty Training: (Not Included Above)	Location		City/State	Type of Service	Dates
Teaching Appointments: (Past/Present)	Name of Facility	Address	City/State	Faculty Rank	Dates:
Hospital Affiliations: (Current or Applied for)	Name & Location			Status	Dates
Previous Practice (Activity since Internship/ Residency)	Practice Name/Nature & Location				Dates
Military Service: (optional)	Branch of Service		Rank		Dates
Membership in Professional/ Specialty Societies:	Organization Name	Address			Dates
2 Peer References By SCCMS Members Only	Name		Telephone #		# mos./yrs. known
	1. _____				
	2. _____				
DEA Registration #	Date Issued	Expiration Date	ECFMG#		
Professional Liability:	Carrier	Address	Policy #	Limits	
Languages other than English	Spoken by Physician		Spoken by Office Staff		
Marital Status (optional)	Name of Spouse (optional)				

Please send completed and signed membership application to:

SANTA CRUZ COUNTY MEDICAL SOCIETY

1975 Soquel Drive #215
 Santa Cruz CA 95065-1821
 Phone: (831) 479-7226 Fax: (831) 479-7223
 Email: sccms@cruzmed.org

Revised 8/24/2009



Santa Cruz County Medical Society

Advocating for patients and physicians

APPLICATION INFORMATION RELEASE

1. By signing this form, I grant permission and consent for the Santa Cruz County Medical Society to obtain from all present and past hospital affiliations, information regarding staff privileges and actions relating thereto, and all information from former medical societies, medical school affiliations, partners and/or associates and release any and all such information to the Santa Cruz County Medical Society.

2. I further agree, as evidenced by the attached application for membership, to furnish the Medical Society with all information relative to any claim or action filed against me for malpractice, and I authorize and consent for the Medical Society to obtain from my present and/or past liability insurance carriers, any all information regarding insurance coverage, premiums, claims, and suits against me as well as settlements made on my behalf.

Name _____
(please print)

Date _____

Signature _____