



Membership

Application

Serving Medicine...Serving the Community

Since 1892

Maricopa County Medical Society

326 E. Coronado

Phoenix, AZ 85004

602-252-2015

602-256-2749 (Fax)

Visit us on the web at www.medical-society.com

SOCIETY
USE
ONLY

PERSONAL INFORMATION

NAME: _____ TITLE: _____
LAST FIRST MIDDLE MD, DO, OTHER (SPECIFY)

HOME: _____
STREET CITY STATE ZIP CODE

HOME PHONE: () E-MAIL ADDRESS: _____

DATE RECEIVED

BIRTHDATE: _____ BIRTH PLACE: _____ SEX: _____
CITY STATE COUNTRY

FOREIGN LANGUAGES (other than English): _____

STATUS

ARIZONA LICENSE: _____ SPOUSE: _____
NUMBER DATE OF ISSUE FIRST LAST TITLE

EFFECTIVE DATE

OFFICE ADDRESS

(If more than one, list each office & address)

For mailing please use: Main office address Second office Third office Home address P.O. Box

AMOUNT PAID

1) _____
CORPORATE NAME MAIN OFFICE STREET ADDRESS SUITE

CITY STATE ZIP CODE CONTACT NAME (Secretary, nurse, etc.)

TYPE OF PAYMENT

PHONE BACK OFFICE PHONE FAX

2) _____
CORPORATE NAME SECOND OFFICE STREET ADDRESS SUITE

CITY STATE ZIP CODE CONTACT NAME (Secretary, nurse, etc.)

PHONE BACK OFFICE PHONE FAX

3) _____
CORPORATE NAME THIRD OFFICE STREET ADDRESS SUITE

CITY STATE ZIP CODE CONTACT NAME (Secretary, nurse, etc.)

PHONE BACK OFFICE PHONE FAX

TYPE OF PRACTICE

Check appropriately

Solo Group *Type of ownership:* Private Corporate Management Group, Hospital, etc.

Name of corporation: _____

SPECIALTY CODES

Hospital Based: _____ Government: _____

Specialty: _____ Accepting Referrals: Yes No

Specialty: _____ Accepting Referrals: Yes No

Specialty: _____ Accepting Referrals: Yes No

Board Certifications: _____
NAMES AND DATES

NAMES AND DATES — COPY OF CERTIFICATE MUST BE ENCLOSED —

Local Hospital Affiliations: _____

RECENT PHOTO MUST BE SUBMITTED WITH APPLICATION

EDUCATION

| | | | | |
|------------------------|----------------|-------------------|--------------|------------|
| MEDICAL SCHOOL: | FACILITY _____ | CITY, STATE _____ | DEGREE _____ | DATE _____ |
| INTERNSHIP: | FACILITY _____ | CITY, STATE _____ | DEGREE _____ | DATE _____ |
| RESIDENCY: | FACILITY _____ | CITY, STATE _____ | DEGREE _____ | DATE _____ |
| RESIDENCY: | FACILITY _____ | CITY, STATE _____ | DEGREE _____ | DATE _____ |
| RESIDENCY: | FACILITY _____ | CITY, STATE _____ | DEGREE _____ | DATE _____ |
| FELLOWSHIP: | FACILITY _____ | CITY, STATE _____ | DEGREE _____ | DATE _____ |
| FELLOWSHIP: | FACILITY _____ | CITY, STATE _____ | DEGREE _____ | DATE _____ |

HEALTH PLAN PARTICIPATION

Please list all health plans in which you participate

ADDITIONAL MEDICAL ASSOCIATIONS

(Specialty, State, Etc.)

REFERENCES

List two physicians who have personal knowledge of your current abilities and ethical character, who will provide specific written comments on these matters upon request from the Maricopa County Medical Society

1. Name: _____ Street Address: _____

City _____ State _____ Zip Code _____ Phone Number _____

2. Name: _____ Street Address: _____

City _____ State _____ Zip Code _____ Phone Number _____

SPONSORS

Signatures of two members of the Society, in good standing, as Sponsors

Name: _____ PLEASE PRINT

Name: _____ PLEASE PRINT

Signature: _____

Signature: _____

OTHER PERTINENT INFORMATION

Name of malpractice insurance carrier: _____

Have you ever been denied professional liability insurance; or has your professional liability insurance ever been terminated or not renewed? Yes ____ No ____ *If yes, please explain on separate sheet of paper*

Have there been or are there currently pending any malpractice claims, suits, or settlements or arbitration proceedings or complaints filed involving your professional practice? Yes ____ No ____

Has any license entitling you to practice medicine and/or surgery in any jurisdiction been investigated, refused, suspended, limited, revoked, or been voluntarily relinquished? Yes ____ No ____
If yes, please explain on separate sheet of paper

Are you currently under investigation or have you ever been subject to disciplinary or corrective action such as admonition, reprimand, censure, probation, nonprovisional supervision, suspension, termination, revocation of privileges by any medical staff, hospital, professional organization or licensing authority? Yes ____ No ____
If yes, please explain on separate sheet of paper

Have you ever been denied membership, privileges, appointment or employment by any medical staff, medical society, hospital or professional organization? Yes ____ No ____
If yes, please explain on separate sheet of paper

Have you ever withdrawn your application or resigned from employment on the staff of any hospital, institution, or medical organization in lieu of being denied membership or privileges or being subject to corrective or disciplinary action? Yes ____ No ____ *If yes, please explain on separate sheet of paper*

LAST 10 YEAR'S PRACTICE

| Dates | Location |
|-------|----------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

The undersigned has read this application and submits the same subject to the provisions of the Articles of Incorporation of the Maricopa County Medical Society, and particularly Articles V and VI thereof, a copy of which is included and made a part of this application, and hereby agrees, in case of his/her election, that his/her membership in the Maricopa County Medical Society shall be in strict compliance with all the By-Laws, rules and regulations thereof.

ARTICLE V

SECTION 1. Every legally licensed practitioner of medicine or surgery in the County of Maricopa, State of Arizona, who is of good moral and ethical standing, who does not support or claim to practice sectarian medicine, and who possess the qualifications set out in these Articles and in the By-Laws of this Society, shall be eligible to membership.

SECTION 2. The Society shall be the sole and exclusive judge of the qualifications of membership of its applicants or members, whether applicants or members by transfer or otherwise, and the vote of the Society upon applications for membership shall be conclusive upon the question of the right to membership.

SECTION 3. The Society shall have the power from time to time to prescribe qualifications for membership, subject to these Articles and shall have the power to amend, add or remove such qualifications as it in its unfettered discretion deems most conducive to the welfare of the Society and most in consonance with its aim and purposes.

ARTICLE VI

Neither the members of this Society nor their private property shall be liable in any manner for any corporate debts, obligations, undertakings or for any damages incident to or arising out of any of the corporate actions or conduct of the corporation's affairs.

INFORMATION RELEASE

- I hereby apply for membership in the Maricopa County Medical Society and will submit annual dues when due and payable if elected to such membership.
- I hereby authorize all individuals, institutions, and entities (past, present, and future) including all professional liability insurers with which I have had or currently have professional liability insurance, who have knowledge concerning my qualifications and other information requested in this application to consult with and release relevant information and records to the Maricopa County Medical Society. I further authorize the use of the pictures provided by me both for internal and external procedures.
- I further agree, as evidenced by this signed application for membership, to furnish the Society with all information relative to any claim or action filed against me for malpractice, and I authorize and consent for the Society to obtain from my present and/or past liability insurance carrier any and all information regarding insurance coverage, premiums, claims and suits against me as well as settlements made on my behalf.

NAME: _____
PLEASE PRINT

DATE: _____

SIGNATURE: _____

*****PLEASE RETURN THE FOLLOWING WITH YOUR APPLICATION*****

- Completed application,
- Copy of board certification(s),
- Curriculum Vitae (if available),
- Recent black and white photo (for publication in the *Round-up* and the MCMS Pictorial Directory),
- Dues check (please make payable to MCMS) or Credit Card information (please see below)

NAME ON ACCOUNT: _____

TYPE OF ACCOUNT: VISA MASTERCARD AMERICAN EXPRESS

ACCOUNT/CARD NUMBER: _____ - _____ - _____

EXPIRATION DATE: ____/____/____ AMOUNT PAID: \$ _____

SIGNATURE OF CARD HOLDER: _____