

Thank you for your interest in joining CMA and Placer-Nevada County Medical Society.

To begin processing your membership, please fill out the information requested on the following application.

1. YOU MUST FILL OUT AND COMPLETE THE 8 QUESTION DECLARATION FORM BEFORE SUBMITTING THE APPLICATION.
2. YOU MUST HAVE YOUR **MEMBERSHIP FEE INCLUDED WITH APPLICATION** BEFORE WE CAN PROCESS YOUR FORM YOUR APPLICATION WILL BE PROCESSED AND APPROVED BY YOUR LOCAL MEDICAL SOCIETY. To find out your current status (New or Former) for payment requirements please call (530) 822-7770.
3. YOU MAY ATTACH YOUR CV HOWEVER WE DO NEED YOUR CORRECT CONTACT INFORMATION (I.E. EMAIL, ADDRESS, CONTACT PHONE NUMBER).

When you are sure all information is correct, print out the document, sign and either fax, or mail the completed application to our Placer-Nevada County Medical Society (see the information listed below).

If you have any questions, please contact us, the information is listed below. We will be happy to assist you:

Cheryl Brandwood, Executive Director

Placer-Nevada County Medical Society
P.O. Box 2478
Marysville, CA 95901
Office Phone (530) 822-7770 Fax (530) 751-7770
Email: pncms_exec@syix.com Website: www.pncms.org

YOU MAY ATTACH YOUR CV, HOWEVER ALL CONTACT INFORMATION MUST BE CORRECT: EMAIL, MAILING, TELEPHONE.
 Thank you for your interest in joining CMA and Placer-Nevada County Medical Society



**Placer - Nevada County Medical Society
 APPLICATION FOR MEMBERSHIP**



Please type or print in black ink - fill in all blanks. Mandatory fields are **Yellow** underlined.
 If more than one office, please list additional office address on a separate sheet of paper.
 A California Participating Physician Application may be substituted for this membership application.

Date Received:

Name:(As shown on license)		Last	First	Middle	Other Name Used, If Any		
Birthdate	Place of Birth	Ethnicity(optional)		Gender: male <input type="checkbox"/>	female <input type="checkbox"/>		
				Social Security #			
Name of Corporation/Practice:			Group Affiliation:				
Primary Office:	Street Address	City	ZIP	Telephone #	FAX #	E-mail #	
Residence:	Street Address	City	ZIP	Telephone #	FAX #		
SEND MAIL TO:	Office	Home	Other Address:				
California License #	Date Issued	Date Expires	Other State Licenses (State-Date Issued)				
Medical School	Location			Check Degree	MD or	Date	
					DO		
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				
<i>Please select/check the Practice Arrangement/Mode of Practice that best describes your practice:</i>							
<input type="radio"/>	Solo/Small (1-4 phys. grp/corp)	<input type="radio"/>	Medium (5-150 phys. grp/corp)	<input type="radio"/>	Large (150-1,000 phys. grp/corp)	<input type="radio"/>	Very Large (1,000+)
<input type="radio"/>	Academic Practice	<input type="radio"/>	Hospital-Based Practice	<input type="radio"/>	Government-Employed Physician	<input type="radio"/>	Fully Retired
<input type="radio"/>	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.

Postgraduate/ Fellowship:	Institution	Address	State	Dept.	Dates
Specialty Training: (Not Included Above)	Location		City/State	Type of Service	Dates
Teaching Appointments: (Past/Present)	Name of Facility	Address		State Faculty Rank	Dates
Hospital Affiliations:	Name & Location			Status	Dates
(Current or Applied for) Practice (Activity since Internship/ Residency)	Previous	Practice Name/Nature & Location			Dates
Military Service: (optional)	Branch of Service		Rank		Dates
Membership in Professional/ Specialty Societies:	Organization Name		Address		Dates
Peer References:	Name	Mailing Address		Telephone #	# mos./yrs. known
(or Sponsors)	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		
<p><small>"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.</small></p>					
APPLICANT'S SIGNATURE:				DATE: _____	
Marital Status(optional)		Name of Spouse:			

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS “YES”, PLEASE PROVIDE FULL DETAILS ON A SEPARATE SHEET.

- 1. Have your privileges at any hospital ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed, or is any such action pending? Yes No
- 2. Have you ever resigned from a hospital staff to avoid disciplinary action? Yes No
- 1. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes No
- 3. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending? Yes No
- 4. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services by Medicare, Medi-Cal, or any public program, or is any such action pending? Yes No
- 6. Do you presently use any drugs illegally? Yes No
- 6. Have any judgements been entered against you, or settlements been agreed to by you within the last Seven (7) years, in professional liability cases, or are there any filed and served professional liability Lawsuits/arbitrations against you pending? Yes No
- 7. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? Yes No

“I hereby affirm that the information submitted in this application 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 or cancellation of my membership.”

I hereby consent to the disclosure, inspection, and copying of information and documents relating to my credentials, qualifications, and performance by and between the state and county medical associations and other health care organizations (e.g., hospital medical staffs, medical groups, IPAs, health plans, medical societies, medical schools, professional associations, etc.) for the purpose of evaluating this application and, if accepted, my continuing membership. I hereby release all persons and entities, including the state and county medical societies, their employees and agents, and all persons and entities providing credentialing information to them, from any liability they might incur for their acts, omissions, and/or communications arising from this application or any membership decision, to the extent those acts, omissions and/or communications are protected by state and federal law. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications.

Signature: _____ **Date:** _____

***You must complete all 8 questions before we can complete the application process.**