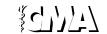


HUMBOLDT-DEL NORTE MEDICAL SOCIETY



A P P L I C A T I O N F O R M E M B E R S H I P

Please type or print in black ink - fill in all blanks. Additional sheets may be attached if necessary.

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:								Revised: 6/19	/98
Name: (As shown on license) Last			First	st Middle		Other Name U		Jsed, If Any	
Birth date (option	al) Plac	ce of Birth	(optional)	Ethnic	ity(optional)	Gender(optio	onal)	Social Sec	curity #
Name of Corporation/Practice:				Group Affiliation:		<u>UPIN:</u>			
Primary Office:	Street Addr	ess	Ci	ty	ZIP	Telephone #	FAX #	e	-mail #
Residence:	Street Addr	ress	Ci	ty	ZIP	Telephone #	FAX #		
SEND MAIL TO:	Office X	Home	Other Add	ess:					
California License	e# Date	Issued	Date Ex	apires		Other State I	Licenses (S	State-Date I	ssued)
Has your medical licer pending? Yes ! Medical School						led, or placed on a p h to this application)		y status - or is s	Such action Date
Internships:	Institution		Addres	s	State	Dept.		Dates	
Residencies:	Institution		Addres	s	State	Dept.		Dates	
Primary Specialty	7	Second	dary Specialty			Special Interests			
American Board (Certification	n(s)/Date(s)						
Medical Society M	lembership	s:			Organiza	tions/Dates			
Please select/check the Solo/Small (1-4 ph Academic Practice Administrative Me	ys. grp/corp)	Me	de of Practice tha dium (5-150 phys spital-Based Prac	. grp/corp)	Large	:: (150-1,000 phys. gr nment-Employed Pl		Very Lai Fully Ret	rge (1,000+) ired
The underwith the Constitution further agrees that he doubtful point in pro	n & Bylaws a ie/she will rec	and Princip cognize the	les of Medical I authorized Offi	Ethics of tl cers of sai	he AMA, the CN d Society & Ass	ociations as the pr	onent Medi oper and so	ical Society.	The undersigned
"I hereby	affirm that th	ie informat	ion provided on	this Appl	ication for Mem	bership, and any	addenda th	ereto 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.

Yes, this application includes membership with the American Medical Association.

DATE:	
	DATE:

APPLICATION FOR MEMBERSHIP

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g					
Postgraduate/	Institution	Address	State	Dept.	Dates
Fellowship:					
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: (Current or Applied for)	Name & Location		Status	Dates	
Previous Practice (Activity since Residency)	Practice Name/Nature & Location			Dates	
Military Service: (optional)	Branch of Service	Rank		Dates	
Membership in Org Professional/ Specialty Societies:	anization Name	Address		Dates	
Peer References: (or Sponsors)	Name	Mailing Address	Telephone #	# mos./yrs	s. known
DEA Registration #	Date Issued	Expiration Date		ECFMC	 G#
Professional Liability:	Carrier	Address		Policy # L	imits
Languages Other Than English	Spoken by Physician			Spoken by O	office Staff
Marital Status(optio	nal)	Name of Spouse(optional	l)		

APPLICATION FOR MEMBERSHIP

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IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE PROVIDE F SEPARATE SHEET.	ULL DETAILS ON A
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?	YesNo
2. Have you ever resigned from a hospital staff to avoid disciplinary action?	YesNo
3. Have you ever been convicted of any crime (other than a minor traffic violation)?	YesNo
4. 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?	YesNo
5. 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?	YesNo
6. Do you presently use any drugs illegally?	YesNo
7. 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?	YesNo
8. 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?	YesNo
"I hereby affirm that the information submitted in this application and any addenda thereto is true, cur complete to the best of my knowledge and belief and is furnished in good faith. I understand that material complete to the best of my knowledge and belief and is furnished in good faith. I understand that material complete to the best of my knowledge and belief and is furnished in good faith. I understand that material complete to the best of my knowledge and belief and is furnished in good faith.	
I hereby consent to the disclosure, inspection, and copying of information adn documents relating to my capalifications, and performance by and between the state and county medical associations and other health continuing medical staffs, medical groups, IPAs, health plans, medical societies, medical schools, professional apurpose of evaluating this application and, if accepted, my continuing membership. I hereby release all persociated including the state and county medical societies, their employees adn agents, and all persons and entities profing information to them, from any liability they might incur for their acts, omissions, and/or communications arise or any membership decision, to the extent those acts, omissions and/or communications are protected by state understand and agree that I, as an applicant, have the burden of producing adequate information for proper of professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications.	are organizations (e.g., associations, etc.) for the ons and entities, viding credentialing ing from this application e and federal law. I evaluation of my
Signature:Date:_	