HUMBOLDT-DEL NORTE MEDICAL SOCIETY

APPLICATION FOR MEMBERSHIP

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 Middle Other Name Used, If Any**

Birth date (optional) Place of Birth(optional) Ethnicity(optional) Gender(optional) Social Security #

Name of Corporation/Practice: Group Affiliation: UPIN:

Primary Office: Street Address City ZIP Telephone # FAX # e-mail #

Residence: Street Address City ZIP Telephone # FAX #

SEND MAIL TO: Office X Home Other Address:

California License # Date Issued Date Expires 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? ___ Yes ___ No ***(If Yes, please provide details on a separate sheet of paper and attach to this application)***

Medical School Location Degree 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:

_ Solo/Small (1-4 phys. grp/corp) __ Medium (5-150 phys. grp/corp) __ Large (150-1,000 phys. grp/corp) __ Very Large (1,000+)
__ Academic Practice __ Hospital-Based Practice __ Government-Employed Physician __ Fully Retired
__ 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.

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

APPLICANT'S SIGNATURE:_____ DATE:_____

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: (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 Professional/ Specialty Societies:	**Organization Name**		**Address**	**Dates**	
Peer References: (or Sponsors)	**Name**	**Mailing Address**	**Telephone #**	**# mos./yrs. known**	
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)**			

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

3. Have you ever been convicted of any crime (other than a minor traffic violation)? __Yes __No

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? __Yes __No

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? __Yes __No

6. Do you presently use any drugs illegally? __Yes __No

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? __Yes __No

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? __Yes __No

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"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 adn 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 adn 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:**_____