ST LUCIE/OKEECHOBEE COUNTY MEDICAL SOCIETY
MEMBERSHIP APPLICATION

PO Box 13318 · Fort Pierce, FL 34979 (772) 812-7180 Phone · (772) 871-0348 Fax
E-mail: stlucieokeemedsociety@yahoo.com
Website: Medical-Society.Org

DEMOGRAPHIC INFORMATION (PLEASE PRINT)

Last Name: _____ First Name: _____ Middle _____ Degree: _____

AMA Medical Ed #: _____ Florida Medical License #: _____

Date of Birth: _____/_____/_____ Sex ☐ Male ☐ Female Spouse's Full Name: _____

Practice/Group Name: _____

Practice/Group Administrator: _____

Practice Type: ☐ Solo ☐ Group ☐ Employed ☐ Government Based ☐ Academic ☐ Other: _____
Please Specify

Primary Specialty: _____ Secondary Specialty: _____

CONTACT AND MAILING INFORMATION

To Better Serve You, Please Provide Complete Contact Information. Do You Prefer to Contacted at ☐ **Home** ☐ **Office**

Office Address: _____ Suite #: _____

City: _____ State: _____ Zip: _____

Office Phone: (_____) _____ Office Fax: (_____) _____

E-Mail: _____

****

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Home Fax: (_____) _____

E-Mail: _____

EDUCATION

Medical School: _____ Degree: _____ Date: _____

Internship: _____

Residency: _____

Fellowship: _____

BOARD CERTIFICATIONS

Name of Board: _____ Certified In: _____ Date: _____

Name of Board: _____ Certified In: _____ Date: _____

Name of Board: _____ Certified In: _____ Date: _____

HOSPITAL AFFILIATIONS

Hospital (Primary): _____ City/State: _____

Hospital (Secondary): _____ City/State: _____

Hospital (Other): _____ City/State: _____

MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

Members abide by the AMA principles of Medical Ethics and the Bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign and date. If you answer yes to any of these questions, please attach complete information.

Yes	**No**	
☐	☐	Have you ever been convicted of fraud or a felony?
☐	☐	Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.
☐	☐	Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society(ies).

The foregoing information is true and complete.

Signature: _____ Date: _____

COMPLETE AND RETURN

Please Make Check Payable to: St Lucie/Okeechobee County Medical Society and return to **PO Box 13318, Fort Pierce, Florida, 34979**.

Annual Membership Dues: ☐ **Active (New): $300.00** ☐ **Active (Renewal): $200.00**
☐ **Student: $50.00** ☐ **Retired: $50.00**

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The endorsement, deposit or negotiation of any applicant's check does not constitute admission into or acceptance of membership by the CMS or FMA. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted will receive a check refunding the amount sent in.