APPLICATION FOR MEMBERSHIP

NASSAU COUNTY MEDICAL SOCIETY / NASSAU ACADEMY OF MEDICINE
and the MEDICAL SOCIETY OF THE STATE OF NEW YORK

☐ I also apply to the AMERICAN MEDICAL ASSOCIATION

Categories of Membership: ☐ Regular member ☐ Intern or Resident ☐ First Year Practice ☐ Second Year Practice

NAME: _____ Birth Date: _____ ☐ MALE ☐ FEMALE

Office Address: _____
Street City State Zip

Office Phone: _____ Fax: _____ E-mail: _____

Residence: _____
Street City State Zip

Residence Phone: _____ For mail use: ☐ home address ☐ office address

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Has your license to practice medicine ever been denied, suspended or revoked by any government agency? ☐ No ☐ Yes

Have you ever been censored, suspended, expelled or been disciplined by any professional society, licensed health care facility or other? ☐ No ☐ Yes

Have you ever been arrested or charged with any crime or violation of law other than traffic violations? ☐ No ☐ Yes

If YES to any of the above, indicate where, when and why: _____

Have you ever been a member of another county medical society? ☐ No ☐ Yes If so, where? _____

New York State medical license number: _____ Date issued: _____

Specialty: _____ Board Certified? ☐ No ☐ Yes Date: _____

If Board Certified, what Board(s)? _____ MEDICARE NPI #: _____

Workers' Compensation Board Rating: _____ Date: _____ Number: _____

RECORD OF MEDICAL EDUCATION AND PRACTICE

Medical College: _____ Graduation Date: _____ ECFMG # _____

Internship/Residency/Fellowship Program(s):

Hospital/Facility: _____ Program: _____ Dates: _____
Hospital/Facility: _____ Program: _____ Dates: _____
Hospital/Facility: _____ Program: _____ Dates: _____

Current Hospital/Clinic Affiliations: _____

ATTESTATION

In applying for membership, I agree to comply with the Bylaws, rules and regulations of the Nassau County Medical Society, District Branch and the Medical Society of the State of New York, and verify that the information presented is accurate:

Signature: _____ Date: _____

This application must be submitted with the appropriate dues payment: ***refer to 2011 Explanation of Dues***

If you're interested in working on a Society committee, visit the website at NACMED.ORG for a complete listing of committees and then contact us via email or phone.

TO BE COMPLETED BY NCMS

SPONSORS: The undersigned active members of the NCMS, having reviewed this application, recommend the applicant for election to membership:

Signature: _____ Signature: _____
Printed Name: _____ Printed name: _____
Date: _____ Date: _____