CMS Membership/Rate Information	
$200	Active
$100	1st Yr Practice after Residency
$150	2nd Yr Practice after Residency
$100	Semi-Retired
$ 50	Retired

Martin County Medical Society Membership Application

Please Return Application and Membership Dues to:

Martin County Medical Society Medical Office Bldg.
2150 SE Salerno Road, Ste 108 Stuart, FL 34997
(772) 419-2991 Fax (772) 419-2992

PERSONAL INFORMATION (please print or type)

____ ☐ MD ☐ DO
Last Name First Middle

AMA Medical Education # :________________________

FL Medical License #: ________________________

Sex: ☐ Male ☐ Female Date of Birth:____/ ______ / _______

Spouse's Full Name:________________________

Practice/Group Name:________________________

Practice/Group Administrator:________________________

Practice Type: ☐ Solo ☐ Group ☐ Employed ☐ Government Based ☐ Academic ☐ Other

Primary Specialty: ________________________

Secondary Specialty: ________________________

Name of FMA/MCMS Member that recruited you:________________________

MAILING INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at ☐ HOME ☐ OFFICE

____
Office Address Home Address

____
Office City/State/Zip Home City/State/Zip

____
Office Phone Home Phone

____
Office FAX Home FAX

____
Email Address Email Address

EDUCATION

Medical School:________________________

Degree:________________________ Date:____________

Residency/Fellowship________________________ Date____________

OVER ➔

BOARD CERTIFICATIONS

1. Name of Board: ____

Certified in ____ Date: ____________

2. Name of Board: ____

Certified in ____ Date: ____________

HOSPITAL AFFILIATIONS

1. Hospital (Primary) ____

City: ____

2. Hospital (Secondary) ____

City: ____

MEMBERSHIP APPLICATION & 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 full 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

PAY BY Check Payable: MARTIN COUNTY MEDICAL SOCIETY

Amount: ______________________ Check#: ______________________

Signature: ____

The endorsement, deposit or negotiation of an 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 to membership will receive a check refunding the amount sent in.