

**DCMS Membership
Rate Information**

\$295 Active Yearly Dues
\$ 50 One-time Entrance Fee

Duval County Medical Society Membership Application

**Please Return Application and Membership Dues
to Duval County Medical Society 555 Bishopgate Lane
Jacksonville, Florida 32204
(904)355-6561 / Fax:(904)353-5848**

PERSONAL INFORMATION (please print or type)

_____ MD DO
Last Name First Middle
FL Medical License #: _____ NPI #: _____
Sex: Male Female Date of Birth: ___/___/___ Birthplace: _____
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 DCMS 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: _____ Date: _____
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: _____

REFERENCES

Please provide name of three (3) physicians who are currently DCMS members to serve as personal reference:

Name	Address	City	Zipcode
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The following **optional** items/documents can be submitted with your application:

1. Color or black/white photo.
2. Copy of current Florida medical license.
3. Copy of all training certificates (internship, residency, fellowship)
4. Copy of medical degree.

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

In the past ten (10) years have you been convicted of fraud or a felony?

In the past ten (10) years, has any action, in any jurisdiction, been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.

In the past ten (10) years have you 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.

By signing below I understand that by providing my fax number, I hereby consent to receive faxes sent by or on behalf of the Duval County Medical Society.

Signature

Date

PAY BY CREDIT CARD (OPTIONAL)

Name on Card: _____ Exp. Date _____

Visa Master Card

Amount: _____ Card #: _____

Signature: _____

The endorsement, deposit or negotiation of an applicant's check does not constitute admission into or acceptance of membership by the CMS. 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.