



Volusia County Medical Society

MEMBERSHIP APPLICATION



PERSONAL INFORMATION (please print or type)

Last Name _____ First _____ Middle Initial _____ MD DO
 AMA Med. Education # : _____ FL Medical License #: _____ Upin #: _____ Social Sec. # _____
 Sex: Male Female Date of Birth: ____/____/____ Spouse's Full Name: _____
 Practice/Group Name: _____ Administrator: _____
 Practice Type: Solo Group Employed Government Based Academic Other
 Primary Specialty: _____ Secondary Specialty: _____

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 _____ Cell Phone _____
 Office FAX _____ Home FAX _____
 Email Address _____ Email Address _____

EDUCATION	Institution	Location	Degree	Dates
-----------	-------------	----------	--------	-------

Medical School:	_____			
Residency	_____			
Fellowship	_____			
Other Post Graduate	_____			

BOARD CERTIFICATIONS	Date Certified	Date Recertified
Name of Board	Certified in	Year Month

HOSPITAL AFFILIATIONS	Full Address
-----------------------	--------------

Hospital	

Do you wish the Volusia County Medical Society to refer patients to you? ____ Yes ____ No

MEMBERSHIP IN MEDICAL ORGANIZATIONS

Are you a member of the FMA? ____ Yes ____ No
 Are you a member of the American Medical Association? ____ Yes ____ No
 Are you a member of your specialty organization? ____ Yes ____ No

Have you ever been convicted of a felony or misdemeanor, or held for violation of Federal or State narcotic laws; or the illegal use or sale of drugs?

Yes No

(If yes, please provide full information.)

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?

Yes No

Have any disciplinary actions ever been taken regarding your hospital privileges or medical society membership?

Yes No

By my signature, I agree to accept and be bound by the Articles of Incorporation and Bylaws of the Association, and the Principles of Medical Ethics of the AMA, together with all future amendments of such Articles of Incorporation, Bylaws or Principles of Medical Ethics which may be duly adopted by the respective organizations.

I hereby release and hold harmless from any liability or loss, the medical society, their officers, agents, employees, and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above-named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership. 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 society.

I hereby certify that the foregoing is true and correct to the best of my knowledge. I understand and agree that if I knowingly made a false representation in this application, or a representation that in the exercise of reasonable care I should have known to be false, the medical society has the authority to reject this application.

Signature

Date

The endorsement, deposit or negotiation of an applicant's check does not constitute admission into or acceptance of membership by the VCMS. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount.

BIOGRAPHICAL RECORD FOR VCMS ARCHIVES

Spouse: Name _____ Date of Birth _____ Place of Birth _____
Occupation _____

Dependents:	Name	Date & Place of birth	Occupation	Relationship
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Professional Work with Specialty:

Places _____
Dates with Title _____
Honors _____
Offices _____ Appointments _____

Hospital Staff:

Membership _____
Dates & Offices _____
Appointments _____
Professional Organizations _____
Titles _____
Offices with Dates _____

Military:

Ranks & Dates _____

Please Return Application and Membership Dues to:
Volusia County Medical Society
P.O. Box 9595,
Daytona Beach, FL 32120-9595



(386) 255-3321 FAX (386) 254-4296

Website: www.fmaonline.org

Email: docs420@aol.com