APPLICATION FOR MEMBERSHIP MEDICAL SOCIETY OF THE STATE OF NEW YORK

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THE SUFFOLK COUNTY MEDICAL SOCIETY

County and State membership is unified. Physicians may join the county society where they practice or where they reside.

NAME _____
Last First MI

HOME ADDRESS _____
City State Zip

TEL # _____ Cell # _____ E-MAIL _____

OFFICE ADDRESS _____
City State Zip

ADDITIONAL OFFICES: □ YES □NO If YES List location and Phone/Fax numbers on the back of the application.

TEL # _____ FAX # _____ PREFERRED MAILING ADDRESS (H or O) _____

DATE OF BIRTH _____ PLACE OF BIRTH _____ □ Male □ Female

MEDICAL SCHOOL _____ YEAR OF GRADUATION _____ □ MD □ DO

ECFMG # (If attended medical school abroad) _____ Website for your Practice _____

CHRONOLOGICAL LIST OF TRAINING, MILITARY SERVICE AND PRACTICE EXPERIENCE SINCE MEDICAL SCHOOL
Please do not leave unexplained intervals and include all current hospital affiliations. Attach a separate sheet if necessary.

DATES	HOSPITAL/LOCATION	POSITION/SPECIALTY

CURRENT HOSPITAL AFFILIATION(S) _____

NYS LICENSE # _____ DATE GRANTED _____ SPECIALTY _____ SUBSPECIALTY _____

BOARD CERTIFIED? _____ WHICH BOARD? _____ DATE ENTERED PRACTICE _____

WORKERS' COMPENSATION BOARD RATING _____ NUMBER _____ DATE _____

GROUP NAME (If applicable) _____ OFFICE MANAGER _____ OM EMAIL _____

LANGUAGES SPOKEN OTHER THAN ENGLISH _____

□ Yes □ No Has your license to practice medicine ever been denied, suspended, revoked, or voluntarily surrendered?
□ Yes □No Have your privileges or employment at any health care facility or entity ever been denied, suspended, terminated, revoked or voluntarily surrendered?
□ Yes □No Are you currently under investigation for medical misconduct by any medical society, hospital medical staff, or disciplinary, licensing or legal agency?
□ Yes □ No Have you ever been arrested or charged with any crime, offense or violation of law other than traffic violations?

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN ON A SEPARATE SHEET

Have you ever been a member of this or any other County Medical Society? □ YES □NO If Yes, County_____

PHYSICIAN'S SIGNATURE_____ DATE_____

RECOMMENDED BY: _____

Please enclose a copy of your current Registration Certificate, CV, Board Certification (if Applicable), Residency Completion Certificate, along with the application and YOUR CHECK. CHECKS ARE MADE PAYABLE TO: Suffolk County Medical Society 1767-14 Veterans Memorial Hwy, Islandia, N.Y. 11749