



CURRENT HOSPITAL AFFILIATION(s) \_\_\_\_\_

NYS License# \_\_\_\_\_ Date Granted \_\_\_\_\_ Specialty \_\_\_\_\_

Board Certified? \_\_\_\_\_ Which Board? \_\_\_\_\_ Date Entered Practice \_\_\_\_\_

Workers Compensation Board Rating \_\_\_\_\_ Number \_\_\_\_\_ Date \_\_\_\_\_

Group Name (If applicable) \_\_\_\_\_ Does the group pay your dues? \_\_\_\_\_

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? \_\_\_\_\_

County \_\_\_\_\_ Dates \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

RECOMMENDED BY \_\_\_\_\_

My dues payment is enclosed.

**Please make check payable to "SUFFOLK COUNTY MEDICAL SOCIETY"**

Please enclose a copy of your current REGISTRATION CERTIFICATE.

**\*\*RESIDENTS AND FELLOWS NEED NOT BE LICENSED TO JOIN\*\***

THE COUNTY SOCIETY MAY REQUIRE OR REQUEST ADDITIONAL INFORMATION