CHICAGO MEDICAL SOCIETY

Membership Application

PERSONAL DATA

Last:_____ First:_____ Middle:_____ ☐ MD ☐ DO
(Entire name should be as shown on medical license)

DOB_____ ☐ Male ☐ Female
mm/dd/yy

Member Level
☐ Regular ☐ Resident/Fellow ☐ Student

_____ _____ _____
Full Name of Medical School | Location of school | Graduation Year

_____ _____ _____ _____ _____
Medical License Number | Issuing State | First Year of Medical Practice - Date | Primary Specialty | Sub-specialty

Practice Type(Check all that apply):

☐ Group ☐ Solo ☐ Academic ☐ Medical Research ☐ Administrative ☐ Employed ☐ Other _____

ADDRESS/COMMUNICATIONS INFORMATION (Please check the preferred address for CMS correspondence)

☐ Primary Office Street/PO Box _____

City/State/Zip _____

☐ Home Street/PO Box _____

City/State/Zip _____

Practice/Group Name: _____

Email: _____

Office Phone: _____

Office Fax: _____

Home Phone: _____

Home Fax: _____

Office Manager: _____

Consent to Fax/E-mail: ☐ **Yes** ☐ **No**

Due to the federal communication regulations, it is necessary for CMS to obtain written consent to continue distributing some information via fax and e-mail. By checking the box above and providing your fax number and e-mail address, you agree to receive from the association and its affiliates promotional notices or solicitations of the availability of goods or services and opportunities related to the practice of medicine. Please note CMS does not sell or make available to the public its membership lists and will be providing the same type of communications as in the past such as HIPAA or other CME seminars and publication discounts available to members. You may opt out at any time by fax (312) 670-3646 or email membership@cmsdocs.org.

RESIDENCY/FELLOWSHIP INFORMATION

	Residency	Fellowship
Program Name	_____	_____
State	_____	_____
Year Completed	_____	_____

Help Us Say Thank You

If you are joining CMS at the suggestion of a current CMS member, we would appreciate the opportunity to say thank you. Please indicate the CMS member who referred you.

_____
(Name of the CMS Member)

AFFILIATIONS

Hospital Affiliation_____

Hospital Affiliation_____

Please submit application to:
Membership Department or fax: (312) 670-3646
Chicago Medical Society
515 North Dearborn St.
Chicago, IL 60654

Please Fax to: Membership Department (312) 670-3646

MEMBERSHIP OPTIONS (please select one):

☐ Regular Member*	$ 98.75	☐ Student Member	FREE
☐ Resident Member	FREE	☐ Practice Administrator	$ 99.00

**Amount includes a 75% First Year Discount, discount will be reduced by 25% in years 2 and 3, with maturity to full dues in year 4.*

With your credit card information below, we can process your membership application. Resident physicians and students receive complimentary membership. Physicians in their first three years of membership receive significant discounts ranging from 25% to 75% off the regular dues amount. Please contact CMS for further information.

PAYMENT INFORMATION

Please Check One:

1) ☐ Visa ☐ Mastercard ☐ American Express **1A)** ☐ Personal Credit Card ☐ Corporate Credit Card

Total: $_____ Expiration Date:_____/_____ CVV(3 or 4 Digit Security Code): _____

CC# _____- _____- _____- _____

PLEASE NOTE: The deposit of a group's check or ACH payment does not confer membership status to the prospective physician. CMS membership is contingent upon verification of the criteria set forth in the CMS bylaws.

Signature: _____ Date: _____

Membership Application and Qualification Questions

Members abide by the bylaws of the Society. 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 a full explanation on a seperate *sheet of paper.*

Yes	*No*	
☐	☐	1. Have you ever been convicted of fraud or a felony?
☐	☐	2. 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 imposed sanctions or conditions.
☐	☐	3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that 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.

The foregoing information is true and complete: Signature _____ Date _____