



Kane County Medical Society Membership Application

***Required Information**

Applicant Information

Check one: Physician Resident Student Fellow ***Degree** MD DO ***Gender** M F

***Last Name (as shown on medical license)** ***First** ***Middle initial** Additional Credentials

Spouse's Last Name (if applicable) Spouse's First Name

***Home Address** ***City** ***State** ***Zip**

***Home or Cell Phone** Text Yes No Home E-mail ***Birth Date (mm/dd/yy)**

***Place of Birth** Medical Education Number (if known)

***Medical School Name** ***City** ***Graduation Year** Maiden Name (if applicable)

Professional Information

***Primary State of Licensure** ***State License Number** Other State Licenses ***Primary Specialty** Yes No Eligible ***Board Certified**

***Practice Name** ***Practice Manager Name** ***Office Manager E-mail**

***Office Address (primary)** ***City** ***State** ***Zip**

***Office Telephone** ***Office Fax** ***Doctor's Office E-mail**

***Beginning Year of Practice (Date)** ***Hospital Affiliation(s)**

***Preferred Email Address:** Office Home ***Preferred Mailing Address:** Office Home

Permission to send: Due to the federal communication regulations, it is necessary for KCMS to obtain consent to distribute information via fax and e-mail. By checking the boxes and providing your fax and email address, you agree to receive emails and facsimiles, including meeting and seminar information, promotional materials about any of our services or products, benefits, manager programs and events and services offered by the Kane County Medical Society.

Membership Application and Qualification Questions

Members abide by the ISMS Code of Medical Ethics and 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 full information.

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you been convicted of fraud or a felony? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 (ies). The foregoing information is true and complete.

Signature _____ Date _____

Kane County Medical Society

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