

Dues have been received for:

Component AMA

CMS # _____

Application for Medical Society Membership in Colorado

For Physicians in Internship / Residency / Fellowship / Preceptorship Programs

DIRECTIONS: Please complete all parts of this application. **A check for the appropriate amount of due must accompany the application.**
Please identify which organization(s) you wish to join at this time.

_____ County Medical Society _____ Colorado Medical Society (CMS) _____ American Medical Association (AMA)

Name: _____ Male Female
Last First Middle Degree

Home: _____ Phone: (____) _____
Street Apt. # City State Zip

Mailing Address: _____
Street Apt. # City State Zip

Date of Birth: _____ Place: _____ Spouse Name: _____
Month / Day / Year City / State / Country

I have been accepted to an Internship Residency Fellowship Preceptorship Program at:

_____ Name of Program and Hospital Street City Zip

Program Department Phone: _____ Expected Date Training to be Completed: _____

E-mail Address: _____ Foreign Language(s) Spoken: _____

Colorado License: _____ ECFMG # (Applicable to Medical Schools Outside of USA) _____
Date Issued Number

Specialty: _____ In CMS Directory please list: Hospital and/or Home

MEDICAL SCHOOL

_____ Full Name of Institution / City / State Degree Mo / Yr

INTERNSHIP

_____ Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

RESIDENCY

_____ Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

_____ Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

FELLOWSHIP / PRECEPTORSHIP (Circle one)

Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

OTHER GRADUATE DEGREES

Full Name of Institution / City / State Degree Began Mo / Yr - Ended Mo / Yr

Have you ever been convicted of a felony? Yes No

Have your hospital medical staff privileges ever been refused, revoked, suspended or reduced? Yes No

Has your license to practice medicine ever been denied, restricted, suspended or revoked? Yes No

Are there any judicial or regulatory actions pending which could result in denial, restrictions, suspension, or revocation of your license to practice medicine? Yes No

Have you ever been expelled from or denied membership in a state or local medical society?..... Yes No

Is there any pending review or disciplinary action with a state or local medical society regarding your membership? Yes No

If you answered yes to any of the above questions, please explain on a separate page and attach to this application.

Have you previously been a member of Colorado Medical Society? Yes No

If so, when? From _____ To _____

Are you a member of, or have you applied for membership to any of the following component medical societies:

- Arapahoe Medical Society
- Clear Creek Valley Medical Society
- Larimer County Medical Society
- Aurora-Adams County Medical Society
- Denver Medical Society
- Pueblo County Medical Society
- Boulder County Medical Society
- El Paso County Medical Society
- Weld County Medical Society

If elected to membership, I agree to conduct myself professionally and personally according to the AMA Principles of Medical Ethics (enclosed) and to be governed and bound by the Constitution and Bylaws of the Society(ies) for which I am applying. Further, I hereby affirm that I have no physical, mental, or emotional condition which would impair my ability to provide an acceptable standard of medical care. I understand that submission of false or fraudulent information may result in denial of membership or expulsion from the society(ies).

I hereby release, and hold harmless from any liability or loss, the Society(ies) for which I am applying, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any and all individuals, organizations, and agencies or their authorized representatives from any liability concerning information provided about my professional competence, ethical conduct, character, and other qualifications for membership.

Applicant's Signature _____ Date _____

Recommended By _____
Program Director's Signature **(Required)** Name Typed or Printed

The undersigned officer of the Society, having fully considered this application and appropriate supporting documents, recommends the following action:

Accepted _____ Rejected _____ Signature _____ Date _____