

# Indian River County Medical Society



Please return application to  
 Indian River County Medical Society  
 P.O. Box 573, Vero Beach, Florida, 32961-0573  
 (772) 562-0123  
 Fax (772) 563-9923

## PERSONAL INFORMATION (please type or print)

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  MD  DO  
 AMA Medical Education No. \_\_\_\_\_ Florida Medical License \_\_\_\_\_ NPI \_\_\_\_\_  
 Sex:  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse's Full Name: \_\_\_\_\_  
 Practice/ Group Name \_\_\_\_\_ Administrator \_\_\_\_\_  
 Practice Type:  Solo  Group  Employed  Government Based  Academic  Other  
 Primary Specialty \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

## EDUCATION

Medical School \_\_\_\_\_ Degree \_\_\_\_\_ Date \_\_\_\_\_  
 Internship \_\_\_\_\_  
 Residency \_\_\_\_\_  
 Fellowship \_\_\_\_\_

## BOARD CERTIFICATIONS

Name of Board \_\_\_\_\_ Certified in \_\_\_\_\_ Date \_\_\_\_\_  
 Name of Board \_\_\_\_\_ Certified in \_\_\_\_\_ Date \_\_\_\_\_

## HOSPITAL AFFILIATIONS

Hospital (primary) \_\_\_\_\_ City \_\_\_\_\_  
 Hospital (secondary) \_\_\_\_\_ City \_\_\_\_\_  
 Name of IRCMS Member who recruited you \_\_\_\_\_

## MAILING INFORMATION

Please provide both addresses for IRCMS use only. Do you prefer to receive mail at  Home  Office

Office Address _____	Home Address _____
Office City/State/Zip _____	Home City/State/Zip _____
Office Phone _____ Office Fax _____	Home Phone _____ Home Fax _____
Office E-Mail Address _____	Home E-mail Address _____

## MEMBERSHIP APPLICATION & QUALIFICATIONS QUESTIONS

Members abide by the AMA Principles of Medical Ethics and the by-laws of the Associations. 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.

Have you ever been convicted of fraud or felony?  Yes  No

Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocations, suspension, limitation, probation, or any other imposed sanctions or conditions.

Yes  No

Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?  Yes  No

I am aware that the 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, or suspension or expulsion from the medical society.

The foregoing information is true and complete.

\_\_\_\_\_  
 Signature Date

The endorsement, deposit or negotiation of an applicant's check does not constitute admission into or acceptance of membership by the IRCMS. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who submit payment and are not admitted to membership will receive a check refunding the amount sent in.