Thank you for choosing to join. Please fill out the information requested on the following page(s). When you are sure all information is correct, print out the document, sign and either fax it to the County listed below or mail it.

If you have any questions, the contact information listed below should be able to assist you.

Alameda-Contra Costa Medical Association
6230 Claremont Ave
Oakland, CA 94618

William N. Guertin, Executive Director
Anna Bailey
E-Mail: abailey@accma.org
Website: http://www.accma.org
TEL: (510) 654-5383
FAX: (510) 654-8959

Office Use Only
Date ____________________

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CMA site app.

ACCMA – CMA

APPLICATION FOR MEMBERSHIP

Alameda-Contra Costa Medical Association
6230 Claremont Avenue, Oakland, CA 94618 • Telephone: (510) 654-5383 Fax: (510) 654-8959

California Medical Association

Name: ____
First Middle Last

Primary Office: ____
Street Suite City Zip Area Code/Phone Area Code/Fax

Secondary Office: ____
Street Suite City Zip Area Code/Phone Area Code/Fax

Residence: ____
Street City Zip Area Code/Phone

Send Mail To: ☐ Primary Office ☐ Home ☐ Other: ____________________

Birth Date: ____________________ Place of Birth: ____________________

Sex: __________ Marital Status: ____________________ Spouse/Partner Name: ____________________

Email ____________________ Languages Spoken: (Other than English) ____________________

Education, Training, and Military Service:

Medical School: ____
School City/State Degree Date

Graduate Training: ____
School City/State Degree Date

Internships: ____
Hospital City/State Dates of Service

____
Hospital City/State Dates of Service

Residencies: ____
Hospital City/State

____
Type of Service Dates of Service

____
Hospital City/State

____
Type of Service Dates of Service

Specialty Training: (Not Included Above) ____
Location City/State Type of Service Date

Postgraduate/Fellowship: ____
Location City/State Type of Service Date

Specialty: ____________________ Subspecialty: ____________________

Practice Concentration: ____

American Board Certified: ____
Specialty Board Date

Military Service: ____
Branch of Service Dates

Licensure:

California Licensure: ____

License No. Date Issued

Other Licensures: ______________________ ______________________

License No. State/Country Date Issued License No. State/Country Date Issued

Has your medical license in California or elsewhere ever been revoked, suspended, or place on a probationary status?
☐ Yes ☐ No. If yes, please provide details on a separate sheet of paper and attach it to this application.

Are you a member of the California Medical Association? ☐ Yes ☐ No.

Have you ever been or are you now a member of any other state or county medical society? ☐ Yes ☐ No. If yes, please provide details.

Name: ______________________ Dates: ____________

Name: ______________________ Dates: ____________

Practice: When did you begin practice following completion of training? (Date) ____________

Exclusive of hospital and/or other training, how long have you been engaged in practice? ____________

How long have you practiced your specialty? ____________

How long have you practiced in Alameda or Contra Costa counties? ____________

Have you practiced elsewhere? ☐ Yes ☐ No. If yes, please provide locations and dates below:

____

____

Hospital Affiliation(s): (Current or Applied For)

____

Professional Societies: Specialty ______________________

Other ______________________

Please check the box below which best describes your practice arrangement/mode of practice:

- ☐ Solo/Small Group (2-4 physicians)
- ☐ Medium Group (5-150 physicians)
- ☐ Large Group (151-1,000 physicians)
- ☐ Very Large Group (1,001+ physicians)
- ☐ Academic Medicine
- ☐ Hospital-Based Practice
- ☐ Government Employed
- ☐ Administrative Medicine
- ☐ Retired

I agree to conform to the bylaws of the Alameda-Contra Costa Medical Association.

I am aware that information submitted in this application and additional information obtained by the Alameda-Contra Costa Medical Association will be verified. I hereby authorize other organizations having information relating to this application, including but not limited to hospital medical staffs, other medical societies, medical schools and governmental and regulatory entities, to release any and all such information to the Alameda-Contra Costa Medical Association. I hereby authorize the Alameda-Contra Costa Medical Association to make known to hospitals and other medical organizations upon request any information the Association may have concerning me.

______________________________ ______________________

Signature of Applicant Date

Sponsor: I, the undersigned member of the Alameda-Contra Costa Medical Association, believe the above-named applicant to be of good moral and professional character and worthy to become a member of this medical association.

______________________________ ______________________

Name (Please Print) Office Address Area Code/Phone