

Thank you for your interest in joining CMA and your county medical society!

To begin processing your membership, please fill out the information requested on the following application. When you are sure all information is correct, print out the document, sign and either fax (or mail) the completed application to your county medical society (see the information listed below).

Your application must be processed and approved by your local society. If you have any questions, the contact information listed below should be able to assist you.

Santa Cruz County Medical Society
1595 Soquel Dr. #340
Santa Cruz 95065
Marcus Kwan, MD, Exec Director
TEL: (831) 479-7226
FAX: (831) 479-7223
E-Mail: sccms@sbcglobal.net
Web: www.cruzmed.org

Please return completed application with \$35.00 application fee and photograph.
Thanks, Marcus Kwan, MD, Exec Director, SCCMS



SANTA CRUZ COUNTY MEDICAL SOCIETY APPLICATION FOR MEMBERSHIP



Please type or print in black ink - fill in all blanks. Additional sheets may be attached if necessary.
If more than one office, please list additional office address on a separate sheet of paper.
A California Participating Physician Application may be substituted for this membership application.

Date Received:

Revised: 04/13/04

Name: (As shown on license) Last First Middle Other Name Used, If Any

Birthdate Place of Birth Ethnicity (optional) Gender (optional) Social Security #

Name of Corporation/Practice: Group Affiliation:

Primary Office: Street Address City ZIP Telephone # FAX # e-mail #

Residence: Street Address City ZIP Telephone # FAX #

SEND MAIL TO: Office Home Other Address:

California License # Date Issued Date Expires UPIN# Other State Licenses (State-Date Issued)

Has your medical license in California or any other state ever been limited, revoked, suspended, or placed on a probationary status - or is such action pending? Yes No (If Yes, please provide details on a separate sheet of paper and attach to this application)

Medical School: Location Check Degree Date
 MD or DO

Internships: Institution Address State Dept. Dates

Residencies: Institution Address State Dept. Dates

Primary Specialty Secondary Specialty Special Interests

American Board Certification(s)/Date(s)

Medical Society Memberships: Organizations/Dates

Please select/check the Practice Arrangement/Mode of Practice that best describes your practice:

- Solo/Small (1-4 phys. grp/corp) Medium (5-150 phys. grp/corp) Large (150-1,000 phys. grp/corp) Very Large (1,000+)
- Academic Practice Hospital-Based Practice Government-Employed Physician Fully Retired
- Administrative Medicine

The undersigned agrees in case of election that membership in this Component Medical Society shall be conditional upon compliance with the Constitution & Bylaws and Principles of Medical Ethics of the AMA, the CMA and the Component Medical Society. The undersigned further agrees that he/she will recognize the authorized Officers of said Society & Associations as the proper and sole authorities to interpret any doubtful point in professional conduct and will at all times abide by and be governed by their interpretations.

I hereby affirm that the information provided on this Application for Membership, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application and/or termination of my membership should I be elected a member of said Society and Association. I understand and agree that acceptance of this application, application fees and/or dues does not constitute approval or acceptance of my membership, and grants me no rights or privileges of membership until such time as I receive notice of approval of my application and my acceptance letter.

Yes, this application includes membership with the American Medical Association.

APPLICANT'S SIGNATURE: _____

DATE: _____

APPLICATION FOR MEMBERSHIP

Postgraduate/ Fellowship:	Institution	Address	State	Dept.	Dates
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Specialty Training: (Not Included Above)	Location	City/State	Type of Service	Dates
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Teaching Appointments: (Past/Present)	Name of Facility	Address	State	Faculty Rank	Dates
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Hospital Affiliations: (Current or Applied for)	Name & Location	Status	Dates

Previous Practice (Activity since Internship/ Residency)	Practice Name/Nature & Location	Dates

Military Service: (optional)	Branch of Service	Rank	Dates
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Membership in Professional/ Specialty Societies:	Organization Name	Address	Dates

2 Peer References By SCCMS Members Only	Name	Mailing Address	Telephone #	# mos./yrs. known
1. _____				
2. _____				

DEA Registration #	Date Issued	Expiration Date	ECFMG#
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Professional Liability:	Carrier	Address	Policy #	Limits
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Languages Other Than English	Spoken by Physician	Spoken by Office Staff
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Marital Status (optional)	Name of Spouse (optional)
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**Please send completed and signed membership application to:
 Santa Cruz County Medical Society
 1595 Soquel Drive, Suite 340, Santa Cruz, CA 95065
 Phone: 831 479-7226 Fax: 831 479-7223**