

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.

Solano County Medical Society  
1252 Travis Blvd Ste A  
Fairfield 94533-4840  
Maryann Eckhout, Executive Dir  
Erika Goodwin, Assoc Executive  
Director  
TEL: (707) 425-7267  
FAX: (707) 425-7268  
E-Mail: [solanomedsoc@sbcglobal.net](mailto:solanomedsoc@sbcglobal.net)



**APPLICATION FOR MEMBERSHIP**

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<b>Postgraduate/ Fellowship:</b>	Institution	Address	State	Dept.	Dates
<b>Specialty Training:</b> (Not Included Above)	Location		City/State	Type of Service	Dates
<b>Teaching Appointments:</b> (Past/Present)	Name of Facility	Address	State	Faculty Rank	Dates
<b>Hospital Affiliations:</b> (Current or Applied for)	Name & Location			Status	Dates
<b>Previous Practice</b> (Activity since Internship/ Residency)	Practice Name/Nature & Location				Dates
<b>Military Service:</b> (optional)	Branch of Service		Rank	Dates	
<b>Membership in Professional/ Specialty Societies:</b>	Organization Name		Address		Dates
<b>Peer References:</b> (or Sponsors)	Name	Mailing Address		Telephone #	# mos./yrs. known
	1.				
	2.				
<b>DEA Registration #</b>	Date Issued	Expiration Date	ECFMG#		
<b>Professional Liability:</b>	Carrier	Address	Policy #	Limits	
<b>Languages Other Than English</b>	Spoken by Physician		Spoken by Office Staff		
<b>Marital Status(optional)</b>	Name of Spouse(optional)				

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IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE PROVIDE FULL DETAILS ON A SEPARATE SHEET.

- 1. Have your privileges at any hospital ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed, or is any such action pending?
2. Have you ever resigned from a hospital staff to avoid disciplinary action?
3. Have you ever been convicted of any crime (other than a minor traffic violation)?
4. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?
5. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services by Medicare, Medi-Cal, or any public program, or is any such action pending?
6. Do you presently use any drugs illegally?
7. Have any judgements been entered against you, or settlements been agreed to by you within the last Seven (7) years, in professional liability cases, or are there any filed and served professional liability Lawsuits/arbitrations against you pending?
8. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

"I hereby affirm that the information submitted in this application 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 or cancellation of my membership."

I hereby consent to the disclosure, inspection, and copying of information and documents relating to my credentials, qualifications, and performance by and between the state and county medical associations and other health care organizations (e.g., hospital medical staffs, medical groups, IPAs, health plans, medical societies, medical schools, professional associations, etc.) for the purpose of evaluating this application and, if accepted, my continuing membership. I hereby release all persons and entities, including the state and county medical societies, their employees and agents, and all persons and entities providing credentialing information to them, from any liability they might incur for their acts, omissions, and/or communications arising from this application or any membership decision, to the extent those acts, omissions and/or communications are protected by state and federal law. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications.

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