

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.

Sonoma County Medical society

3033 Cleveland Ave

Santa Rosa 95403

Cynthia Melody, Executive Director - Rachel Lettiere E-Mail riettiere@scma.org

TEL: (707) 525-4359

FAX: (707) 525-4328

E-Mail: cynthia@scma.org

Web: <http://www.scma.org>



Sonoma County Medical Association APPLICATION FOR MEMBERSHIP



Please type or print in black ink - fill in all blanks. Mandatory fields are **RED** underlined.
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:

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

Birthdate **required** Place of Birth(optional) 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 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 Practic 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: _____

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Postgraduate/ Fellowship:	Institution	Address	State	Dept.	Dates
Specialty Training: (Not Included Above)	Location	City/State	Type of Service	Dates	
Teaching Appointments: (Past/Present)	Name of Facility	Address	State	Faculty Rank	Dates
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	
Membership in Professional/ Specialty Societies:	Organization Name	Address		Dates	
Peer References: (or Sponsors)	Name	Mailing Address	Telephone #	# mos./yrs. known	
	1.				
	2.				
DEA Registration #	Date Issued	Expiration Date	ECFMG#		
Professional Liability:	Carrier	Address	Policy #	Limits	
Languages Other Than English	Spoken by Physician		Spoken by Office Staff		
Marital Status(optional)	Name of Spouse(optional)				

APPLICATION FOR MEMBERSHIP

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: _____