SANGAMON COUNTY MEDICAL SOCIETY

# 2024 Membership Application

Check one:

☐Physician ☐ 1st year*

☐2nd year* ☐3rd year*

☐4th year*

(* Year in practice)

## PERSONAL DATA

Last: _____ First: _____ Middle: _____ ☐MD ☐DO

(Entire name should be as shown on medical license)

Date of Birth _____ ☐Male ☐Female

_____ _____ _____

Full Name of Medical School | Location of school | Graduation Year

_____ _____ _____ _____

IL State License Number | First Year of Medical Practice - Date | Primary Specialty | Sub-specialty

Practice Type (Check all that apply):

☐Group ☐Solo ☐Academic☐ Medical ☐Research ☐Administrative

☐Employed ☐Other _____

**ADDRESS/COMMUNICATIONS INFORMATION (Please check the preferred address for SCMS correspondence)**

Primary Office Street/PO Box_____

City/State/Zip _____

Home Street/PO Box _____

City/State/Zip _____

Practice/Group Name: _____

Email: _____

Office Phone: _____

Office Fax: _____

Home Phone: _____

Home Fax: _____

Office Manager: _____

Consent to Fax/E-mail: ☐Yes ☐No

**RESIDENCY/FELLOWSHIP INFORMATION**

| | Residency | Fellowship |
|---|---|---|
| Program Name | _____ | _____ |
| State | _____ | _____ |
| Year Completed | _____ | _____ |

**AFFILIATIONS**

Hospital Affiliation _____

Hospital Affiliation _____

**SCMS Dues Structure**

| Membership Class | Yearly Dues |
|---|---|
| 1st year practice | $75.00 |
| 2nd year practice | $120.00 |
| 3rd year practice | $160.00 |
| 4th year practice | $205.00 |
| Full/Regular | $250.00 |
| Part Time | $142.50 |
| Emeritus/Retired | $0.00 |
| Student | $0.00 |
| Resident | $0.00 |

**Modes of Payment accepted:**

☐**Check**

☐**ACH Direct Deposit**

☐**PayPal (to scms@scmsdocs.org)**

**(monthly plans also available)**

**Payment by credit card can be made by emailing Ozma@scmsdocs.org**

**Membership Application and Qualification Questions**

Members abide by the SCMS Code of Medical Ethics and the bylaws of the Society.

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

_____ _____

Signature Date

Please submit application to:

Sangamon County Medical Society

1337 Wabash Ave

Springfield, IL 62704

fax: (312) 782-2023

scms@scmsdocs.org