



SANGAMON COUNTY MEDICAL SOCIETY

2018 AFFILIATE APPLICATION

Last: _____ First: _____ Middle: _____ NP PA

DOB: _____ Male Female
mm/dd/yy

Full Name of Medical/Nursing School: _____

Location of School: _____ Graduation Year: _____

IL State License Number: _____

SCMS Member Physician that you are currently working with: _____

Medical Specialties: _____ Languages Spoken: _____

Practice/Group Name: _____

Primary Office Street/PO Box _____

City/State/Zip _____

Phone _____ Fax _____ Email _____

Home Street/PO Box _____

City/State/Zip _____

Home Phone _____ Cell Phone _____

Email _____

Consent to Fax/e-mail: Yes No

Due to the federal communication regulations, it is necessary for SCMS to obtain written consent to continue distributing some information via fax and e-mail. By checking the box above and providing your fax number and email address, you agree to receive from the association and its affiliates promotional notices or solicitations of the availability of goods or services and opportunities related to the practice of medicine. Please note SCMS does not sell or make available to the public its member or affiliate lists and will be providing the same type of communications as in the past such as HIPAA or other CME and/or CEU seminars and publication discounts available to affiliates. You may opt out at any time by fax 217-726-5403 or e-mail at scms@scmsdocs.org

Hospital Affiliation(s): _____

Referral Information: Would you like to be included on our referral list? Yes No

Are you accepting new patients? Yes No

Do you accept Medicaid? Yes No Do you accept Medicare? Yes No

Affiliate Application and Qualification Questions

Members abide by the ISMS/SCMS Code of Medical Ethics and the bylaws of the Society. To assist us in upholding these standards, please provide answers to the following questions, sign and date. If you answer yes to any of these questions, please attach a full explanation on a separate sheet of paper.

1. Have you ever been convicted of fraud or a felony?
YES NO
2. Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any imposed sanctions or conditions.
YES NO
3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff? YES NO

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.

The foregoing information is true and complete: Signature _____ Date _____

Affiliate Payment Options:

Mail check and completed form to the address below or go online at www.scmsdocs.org to complete the form and pay through the SCMS PayPal account. Email: scms@scmsdocs.org or Fax: 217-726-5403

Please make check payable to: Sangamon County Medical Society
1337 Wabash Ave.
Springfield, IL 62704

Annual Affiliate: May 1, 2018 to May 1, 2019

Affiliate fee: \$75