

LEE COUNTY MEDICAL SOCIETY, INC.
MEMBERSHIP APPLICATION AND INFORMATION
13770 Plantation Road, Suite 1 (33912)
Fort Myers, FL 33912

PLEASE RETURN APPLICATION WITH \$100.00 NON-REFUNDABLE PROCESSING FEE!

Enclosed you will find an application for the Lee County Medical Society. Your application must be completed and returned to the Medical Society office for processing. Your application **WILL NOT BE CONSIDERED IF INCOMPLETE IN ANY RESPECT.**

Please be sure when filling out your application that you include all addresses of your practice in Lee County and not your present address outside of Lee County. **Addresses must be complete for physician references, association references, medical schools, internships, residencies and other hospital affiliations.** Zip codes are needed. By including the above you will speed up the application process.

Pictures:

The Lee County Medical Society will need a professional photograph taken within the past year. The photo will be used for the LCMS *Pictorial Directory, Bulletin, and website*. You may mail a photograph with your application or email a jpeg or tif file to awilke@lcmsfl.org; Valerie@lcmsfl.org.

References:

Once your application has been received your references will be checked. Please allow enough time by sending us your application as soon as possible. **Please use only references of your peers (M.D.'s or D.O.'s).** Do not use relatives, non-physicians or **references in Lee County***. The Society reserves the right to contact anyone who might have an opinion concerning your qualifications.

Medical License:

Please provide us with a copy of your Medical License for our records. Your continuing Medical Education number from the American Medical Association is required for dues processing. If you do not have this number leave it blank and we will contact the AMA.

After favorable action by the Committee on Ethical and Judicial Affairs and Board of Governors, your application will be presented to the Membership for their final approval. This process takes approximately three months.

SHAHID SULTAN, M.D., PRESIDENT _____ (239) 343-6906
LEE COUNTY MEDICAL SOCIETY

KULTAR SINGH, M.D., CHAIRMAN
COMMITTEE ON ETHICAL & JUDICIAL AFFAIRS _____ (239) 343-6906
Should you have any questions, please contact the Medical Society office. We will be glad to assist you.

Ann Wilke, Executive Director
Lee County Medical Society, Inc.
Telephone (239) 936-1645

***EXCEPTION:** A physician practicing in the Lee County area for **MORE THAN FIVE YEARS** does not have to provide out of town references, but may use four medical references from the Lee County area or outside of Lee County. Two references in Lee County must be Lee County Medical Society members and no more than two references can come from the applicant's immediate practice.



Membership Application

Please include \$100 application fee
 Lee County Medical Society
 13770 Plantation Road, Suite 1
 Fort Myers, FL 33912
 (239) 936-1645 / Fax: (239) 936-0533

Applicant Information (Please print or type)

Full Name (Print): Last _____ First _____ Middle _____

AMA Medical Education # _____ FL Medical License # _____ MD DO NPI # _____

Sex: Female Male Date of Birth: ___ / ___ / ___ Spouse's Full Name: _____

Place of Birth: _____ Foreign Languages Spoken in Office: _____

Practice/Group Name: _____ Website: _____

Office Manager: _____ Office Manager Email: _____

Practice Type: Solo Group Employed Government Based Academic Other

Primary Specialty: _____ Secondary Specialty: _____

Name of FMA/LCMS Member that recruited you: _____

MAILING INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at HOME OFFICE

Primary Office Address _____ City _____ Zip Code _____

Phone _____ Fax _____ E-Mail _____

Home Address _____ City _____ Zip Code _____

Phone _____ Fax _____ E-Mail _____

EDUCATION/ Work History

INSTITUTION	LOCATION	DEGREE/SPECIALTY	DATES
Medical School			
Internship			
Residency			
Fellowship			
Other Post Graduate			

NAME PRACTICES IN CHRONOLOGICAL ORDER (Account for all time since Medical School. Use additional sheet if necessary)

Practice Name	Address	City, State	Dates
Practice Name	Address	City, State	Dates
Practice Name	Address	City, State	Dates
Practice Name	Address	City, State	Dates

BOARD CERTIFICATION

1. Name of Board _____
Certified in _____ Date: _____
2. Name of Board _____
Certified in _____ Date: _____

HOSPITAL AFFILIATIONS

Hospital (Primary) _____ City _____
Hospital _____ City _____
Hospital _____ City _____
Hospital _____ City _____

REFERENCES

FOUR REFERENCES (Do not use Physicians in Lee County or relatives. Exception: If you practiced in Lee County for over five years then you may use four local references. Please see cover sheet.)

Name _____ Phone _____ Fax _____
Address _____
Name _____ Phone _____ Fax _____
Address _____
Name _____ Phone _____ Fax _____
Address _____
Name _____ Phone _____ Fax _____
Address _____

MEMBERSHIP IN MEDICAL ORGANIZATIONS: Have you ever been a member of the FMA? Yes No
Are you a member of your specialty organization? Yes No _____
Are you a member of the AMA? Yes No

Communication Consent Statement

This Communication Consent Statement is intended to fully comply with the Federal Trade Communications Commission Telephone Consumer Protection Act of 1991. I consent to receive communications sent via regular mail, email, telephone or fax by the Lee County Medical Society. I understand this Consent remains in effect as long as I remain a member of the Lee County Medical Society.

Signature Date

Membership APPLICATION & QUALIFICATION QUESTIONS

Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. 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 full information.

YES NO

- Have you ever been convicted of fraud or a felony?
- 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 other imposed sanctions or conditions
- Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the 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(ies). The foregoing information is true and complete.

Signature Date

Personal Information

Let us know about your interests: hobbies, civic organizations, research, family & children activities, travel, mentoring, etc. _____

The Lee County Medical Society has a *New Physician Mentor Program*. In this program, we assign a LCMS physician member to help acclimate you to your new community and/or to your new professional association. This will help in establishing new professional relationships for you and your mentoring physician.

I would like to participate in the *New Physician Mentor Program* Yes No

Photo Instructions and Member Rate Information

PHOTO INSTRUCTIONS

The LCMS will need a photo taken within the past year. The photo can be mailed with application or emailed to awilke@lcmsfl.org; valerie@lcmsfl.org;

It will be used for the LCMS *Pictorial Directory*, *Bulletin* and *website*.

LCMS MEMBER RATE INFORMATION

- \$395 Lee County Medical Society
- \$50 Retired Physicians
- \$25 LeePAC
- \$85 Alliance (LCMS & FMA)
- \$50 Public Relations Committee
- \$50 McCourt Scholarship

Also Important

- \$420 AMA
- \$420 FMA
- \$250 FMAPAC

Medical Society Use Only

Committee on EJA/Board of Governors Approval

1. _____ Membership (not) recommended, deferred.
2. _____ Membership (not) recommended, deferred.
3. _____ Membership (not) recommended, deferred.

Date

Chair, Committee on Ethical & Judicial Affairs

STATUS

Date application received _____

Date referred to Committee on Ethical & Judicial Affairs _____

Date approved by the Governors _____

Date approved by Society Membership _____

Date

Secretary, Lee County Medical Society



LEE COUNTY MEDICAL SOCIETY, INC.

WAIVER AND RELEASE OF LIABILITY

I, _____, having applied for appointment or reappointment to the Membership of the **Lee County Medical Society** hereby authorize the Committee on Ethical and Judicial Affairs, Board of Governors and Officers of the Lee County Medical Society to contact any references listed by me on my application for membership in the society or to any other physician, person, agency or organization concerning my professional background, character, citizenship or qualifications to be a member of the Medical Society; and, in so instructing the above Boards, Officers, Committees and persons to make this investigation, I hereby agree to hold them and any person or organization answering their inquiries about my qualifications, education, experience, character and citizenship harmless from any claims by me for any statements which they may make concerning me.

I agree that a copy of this release shall be sent to those references listed in this application, together with a request for information concerning me and my background, in order that the people writing references may be free to express their honest opinions about my abilities as a physician and my reputation as a citizen to the officers and officials of the Lee County Medical Society who are considering my application for membership.

"I release and waive all claims related to the **good faith furnishing** or review of the information described above."

SIGNATURE OF APPLICANT

DATE

WITNESSED BY