

**LEE COUNTY MEDICAL SOCIETY, INC.
MEMBERSHIP APPLICATION AND INFORMATION**

**THIS IS AN INVITATION TO JOIN
THE LEE COUNTY MEDICAL SOCIETY
AND SUPPORT THE PROFESSION OF MEDICINE**

LCMS'S MEMBERSHIP VALUE & BENEFITS

WORKERS COMPENSATION INSURANCE – Through the LCMS's Group Program with OptaComp, members receive up to 24.8% of their premium back in the form of a dividend.

MEDICAL LIABILITY INSURANCE – Through the LCMS's Group Program, members receive an annual discount of 5% on their premiums with FPIC / The Doctor's Company.

PRACTICE MANAGEMENT – LCMS routinely communicates with Medicare and insurance companies regarding physicians' economic (getting paid) and enrollment issues. LCMS supports the physicians' office staff with answers to their day-to-day problems.

OTHER NEEDED SERVICES – Available are Healthcare Attorney on Call, Group Purchasing Programs, Mentoring Program and dedicated research for those questions that keep your office running smoothly.

Referrals * Advocacy & Lobbying *** Speakers Bureau**

Unlike other organizations our members join because they choose to, not because they have to!!

We are still the more noble cause... come stand with us! **WITHOUT YOU THERE IS NO VOICE !**

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

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.

Should you have any questions, please contact the Medical Society office. We will be glad to assist you.

PLEASE PROVIDE US WITH A COPY OF YOUR MEDICAL LICENSE FOR OUR RECORDS.

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

RETURN TO: Ann Wilke, Executive Director
Lee County Medical Society
13770 Plantation Road, Suite 1
Fort Myers, FL 33912
Telephone (239) 936-1645



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)

MD DO

Last Name (Print): _____ First _____ Middle _____

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

Place of Birth: _____ FL Medical License #: _____

Practice/Group Name: _____ Website: _____

Office Manager: _____ Office Manager Email: _____

Practice Type: Solo Group Employed Government Based Academic Foreign language _____

Primary Specialty: _____ Secondary Specialty: _____

Name of person referring you to The Lee County Medical Society: _____

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 (OR ATTACHED CV)

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

BOARD CERTIFICATION

Date Board Eligible _____ Name of Board _____ Date Certified _____

Recertification Date _____ Other Boards _____

HOSPITAL AFFILIATIONS

Hospitals _____

TWO REFERENCES NEED TO BE PROVIDED IF YOU DO NOT HAVE HOSPITAL PRIVILIGES IN LEE COUNTY

Name _____ Phone _____ Fax _____

Address _____

Name _____ Phone _____ Fax _____

Address _____

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. ***I PREFER LCMS INFORMATION SENT TO MY FAX# AND/OR EMAIL SHOWN BELOW:***

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 ground 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 or 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



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