



*Required Information

2012 Membership Application Kane County Medical Society

Personal Information

*Circle one: Physician 1st year 2nd Year 3rd Year 4th Year Resident Physician Student *Degree *Gender

*Last Name (as shown on medical license) *First *Middle MD DO M F

Spouse's Last Name (if applicable) Spouse's First Name

*Home Address *City *State *Zip

Home Telephone Home Fax Home E-mail *Birth Date (m/d/y)

*Place of Birth Medical Education Number (if known)

*Medical School Name *City *Graduation Year Maiden Name (if applicable)

Professional Information

*Primary State of Licensure *State License Number Date License Expires (mm/dd/year) Other State Licenses

*Primary Specialty *Board Certified Secondary Specialty Board Certified

*Practice Name *Office Manager Name *Office Manager E-mail

*Office Address *City *State *Zip

*Office Telephone *Office Fax *Doctor's Office E-mail

Secondary Office Address

*Beginning Year of Practice (Date) *Hospital Affiliation(s)

Languages Spoken: _____

*Preferred Email Address: Office Home *Preferred Mailing Address: Office Home

Transferring Members

If you are currently transferring from another county medical society:

County _____ State _____

Dates: From: _____ to: _____

Last year dues paid: _____

Membership Application and Qualification Questions

Members abide by the ISMS Code of Medical Ethics and 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 full information.

Yes No

1. Have you ever been convicted of fraud or a felony?
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?
3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

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 (ies).

The foregoing information is true and complete.

Signature

Date

Payment

Yearly Membership Dues:

Kane County Medical Society: \$325.00 Required

Illinois State Medical Society: \$570.00 Required

IMPAC: \$200.00 Voluntary (Suggested amount)

Choose one of the three payment options:

_____ **Credit Card Visa/MC/Discover/AMEX** (form attached)

_____ **Check** (Make checks payable to Kane County Medical Society)

_____ **Monthly payments** (Monthly continuous membership payments will be automatically deducted from your bank account or credit card on the 10th of the month. Please provide account information on attached form.)

* Physicians in their first four years of practice receive significant discounts ranging from 20% to 80% off the regular dues amount. Resident physicians and students are also provided significant cost savings. Physicians who are part of a group of 10 or more KCMS members qualify for an ISMS group rate. Contact Kane County Medical Society for rate information.

Help Us Say Thank You

If you are joining KCMS/ISMS at the recommendation of a current member, please indicate the member's name so we may recognize them.

Name of KCMS/ISMS Member

Kane County Medical Society

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St. Charles, IL 60175
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FX: 630-584-6703
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www.kcmsdocs.org