



**Capital Medical Society &  
Florida Medical Association  
Membership Application**  
Please Return Application and Membership Dues to:  
Capital Medical Society, 1204 Miccosukee Road  
Tallahassee, FL 32308



**PERSONAL INFORMATION (please print or type)**

\_\_\_\_\_  MD  DO  
 Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
 AMA Medical Education # : \_\_\_\_\_  
 FL Medical License #: \_\_\_\_\_  
 NPI #: \_\_\_\_\_  
 Sex:  Male  Female      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Place of Birth: \_\_\_\_\_  
 Spouse's Full Name: \_\_\_\_\_  
 Practice/Group Name: \_\_\_\_\_  
 Practice/Group Administrator: \_\_\_\_\_  
 Practice Type:     Solo     Group     Employed     Government Based     Academic     Other  
 Primary Specialty: \_\_\_\_\_  
 Secondary Specialty: \_\_\_\_\_  
 Name of FMA/CMS Member that recruited you: \_\_\_\_\_

**MAILING INFORMATION**

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

Office Address \_\_\_\_\_ Home Address \_\_\_\_\_  
 Office City/State/Zip \_\_\_\_\_ Home City/State/Zip \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Office FAX \_\_\_\_\_ Home FAX \_\_\_\_\_  
 Email Address \_\_\_\_\_ Email Address \_\_\_\_\_

**EDUCATION**

Medical School: \_\_\_\_\_  
 Degree: \_\_\_\_\_ Date: \_\_\_\_\_  
 Residency/Fellowship \_\_\_\_\_ Date \_\_\_\_\_

**OVER →**

**BOARD CERTIFICATIONS**

1. Name of Board: \_\_\_\_\_

Certified in \_\_\_\_\_ Date: \_\_\_\_\_

2. Name of Board: \_\_\_\_\_

Certified in \_\_\_\_\_ Date: \_\_\_\_\_

**HOSPITAL AFFILIATIONS**

1. Hospital (Primary) \_\_\_\_\_

City: \_\_\_\_\_

2. Hospital (Secondary) \_\_\_\_\_

City: \_\_\_\_\_

**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

**PAY BY CREDIT CARD (OPTIONAL)**

Name on Card: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Visa  Master Card

Amount: \_\_\_\_\_ Card #: \_\_\_\_\_

Signature: \_\_\_\_\_

***The endorsement, deposit or negotiation of an applicant's check does not constitute admission into or acceptance of membership by the CMS or FMA. Checks received will routinely be negotiated and deposited without a determination of the propriety of the payment or the applicability of the amount. Applicants who are not admitted to membership will receive a check refunding the amount sent in.***