



Peoria Medical Society and Illinois State Medical Society



Application For Membership and Website Physician Info Service Physician Member referred by: _____

* PLEASE TYPE OR PRINT CLEARLY *

DATE OF APPLICATION _____

Personal Information

Please check one: Physician Resident Student
Please check one: MD DO

Last Name First Name Middle

Birthdate Place of Birth (City/State/Country) Male _____ Female _____

Marital Status: Single _____ Married _____ Spouse's Name _____
My spouse is interested in receiving information about the Peoria Medical Society Alliance: _____ Yes _____ No

Home Address in Peoria Area: _____
Street City/State Zip

Telephone Fax

If you are a student, please complete: ME# if known _____ Social Security # _____

Medical School Name Graduation Year

Professional Information

Peoria Office/Group Name: _____

Peoria Office Address: _____
Street City/State Zip

Office Email Address Office Website URL Telephone Fax

Specialty: _____ Specializing within your specialty: _____

Office Manager's Name: _____ Languages: _____

Accepting New Patients: _____ Yes _____ No Accept Public Aid: _____ Yes _____ No Office Hours: _____

Date Beginning Practice in Peoria: _____ Beginning Practice for the First Time? _____ Yes _____ No
If no, what year did you begin practice: _____

Most Recent Practice at: _____
Address/City/State From To

Most Recent Medical Society Membership: _____
Address/City/State From To

Are you currently a member of AMA? _____ Yes _____ No ME Number _____ Paid thru 20 _____

Do you wish to become a member of AMA? _____ Yes _____ No If yes, see reverse for payment options.

Education and Training

Medical School: _____ From _____ To _____ City/State _____
 DEGREE _____

Internship/Residency: _____ From _____ To _____ City/State _____
 DEGREE _____

Internship/Residency: _____ From _____ To _____ City/State _____
 DEGREE _____

Fellowship Training: _____ From _____ To _____ City/State _____
 DEGREE _____

American Boards and License Number

Specialty Board Name _____ Date of Certification _____ Expires _____

Specialty Board Name _____ Date of Certification _____ Expires _____

Illinois License Number _____ Expiration Date _____

Qualification Questions and Signature

If you answer YES to any of these questions, please explain on a separate sheet.

1. Have you ever been denied membership or been subject to disciplinary action in any medical association? ___ Yes ___ No
2. Have you ever been denied a medical license, or has your medical license been suspended or revoked in any state? ___ Yes ___ No
3. Have you ever been convicted of fraud or a felony? ___ 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(ies).

If granted membership, I agree to support the Constitution and Bylaws of the Peoria Medical Society and the Illinois State Medical Society.

Signature

Date

Membership Dues

Payment Options

*Membership in the Peoria Medical Society requires membership in the Illinois State Medical Society. **AMA membership is optional.

	*Peoria Medical Society	and	*Illinois State Medical Society	Optional	**American Medical Association
Regular Physician Dues:	<input type="checkbox"/> \$425	+	<input type="checkbox"/> \$525		<input type="checkbox"/> \$420 (optional)
Regular Resident Dues:	<input type="checkbox"/> \$10	+	<input type="checkbox"/> \$5		<input type="checkbox"/> \$45 (optional)
Regular Student Dues:	<input type="checkbox"/> -0-	+	<input type="checkbox"/> \$2		<input type="checkbox"/> \$20 (optional)

- Check enclosed** payable to Peoria Medical Society: \$ _____
- Please bill me** according to my choices.

*** Due to Security and Fraud issues credit card payments are only accepted by calling the Peoria Medical Society office at 309-692-1192.

NOTE: \$15 of Peoria Medical Society dues is for a one year subscription to *Peoria Medicine* magazine. \$6 of ISMS dues is for a one year subscription to *Illinois Medicine Express*.

Office Use Only

I hereby attest that the above named applicant was duly elected to membership in the Peoria Medical Society at a meeting held on

the _____ day of _____, 20_____.

Signed