



DENVER MEDICAL SOCIETY APPLICATION FOR MEMBERSHIP

DIRECTIONS: Please complete all parts of this application. Payment for the appropriate amount of dues must accompany the application. **Send your application and dues to the Denver Medical Society, 1850 Williams St., Denver, CO 80218.**

Please identify which organization(s) you wish to join at this time.

_____ Denver Medical Society (DMS) _____ Denver and Colorado Medical Societies (DMS/CMS) _____ DMS, CMS, and American Medical Association (AMA)

Name: _____ Gender: _____
Last First Middle Degree

Primary Office Address: _____ Phone: _____

_____ Fax: _____

Email Address: _____

Present or anticipated local practice affiliation (e.g. name(s) of partners, group, etc.) _____ Date you will begin active practice (if applicable) _____

Type of practice: _____ solo _____ same specialty group _____ multi specialty group _____ faculty _____ administration _____ other (specify) _____

Home Address: _____ Phone: _____

For my mailing address please use: _____ office or _____ home In Colorado Medical Society Directory please list: _____ office and/or _____ home

Birthdate: _____ Spouse Name: _____
Month/Day/Year

Colorado License: _____ Other State License(s): _____
Date Issued Number

Specialty: _____ Board Certification: _____
Certifying Board

Original Date of Certification _____ Recertification Date _____ Expiration Date _____

COLORADO HOSPITAL MEDICAL STAFF PRIVILEGES

_____ Name of Institution/City/State _____ Began Mo/Yr – Ended Mo/Yr

_____ Name of Institution/City/State _____ Began Mo/Yr – Ended Mo/Yr

_____ Name of Institution/City/State _____ Began Mo/Yr – Ended Mo/Yr

PRACTICE HISTORY : (include teaching appointments, military and public health service, private practice.)

_____ Location _____ Specialty/Branch of Service _____ Began Mo/Yr – Ended Mo/Yr

_____ Location _____ Specialty/Branch of Service _____ Began Mo/Yr – Ended Mo/Yr

_____ Location _____ Specialty/Branch of Service _____ Began Mo/Yr – Ended Mo/Yr

Foreign Language(s) Spoken: _____

MEDICAL SCHOOL:

Name of Institution/City/State _____ Degree _____ Mo/Yr _____
ECFMG # _____ (necessary if medical school is outside U.S.A.)

INTERNSHIP:

Name of Institution/City/State _____ Specialty _____ Began Mo/Yr – Ended Mo/Yr _____

RESIDENCY:

Name of Institution/City/State _____ Specialty _____ Began Mo/Yr – Ended Mo/Yr _____

Name of Institution/City/State _____ Specialty _____ Began Mo/Yr – Ended Mo/Yr _____

Name of Institution/City/State _____ Specialty _____ Began Mo/Yr – Ended Mo/Yr _____

FELLOWSHIP:

Name of Institution/City/State _____ Specialty _____ Began Mo/Yr – Ended Mo/Yr _____

Name of Institution/City/State _____ Specialty _____ Began Mo/Yr – Ended Mo/Yr _____

OTHER GRADUATE DEGREES:

Name of Institution/City/State _____ Began Mo/Yr – Ended Mo/Yr _____

Have you ever been convicted of a felony? Yes _____ No _____

Have your hospital medical staff privileges ever been refused, revoked, suspended or reduced? Yes _____ No _____

Has your license to practice medicine ever been denied, restricted, suspended or revoked? Yes _____ No _____

Are there any judicial or regulatory actions pending which could result in denial, restrictions, suspension, or revocation of your license to practice medicine? Yes _____ No _____

Have you ever been expelled from or denied membership in a state or local medical society? Yes _____ No _____

Is there any pending peer review or disciplinary action with a state or local medical society regarding your membership? Yes _____ No _____

If you answered yes to any of the above questions, please explain on a separate page and attach to this application.

Indicate if you have previously been a member of _____ Denver Medical Society or _____ Colorado Medical Society. Date _____

Indicate if you belong or if you have applied to any of the following Medical Societies:
_____ Arapahoe Douglas Elbert _____ Aurora/Adams County _____ Clear Creek Valley _____ Boulder

If elected to membership, I agree to conduct myself professionally and personally according to the AMA Principles of Medical Ethics (enclosed) and to be governed and bound by the Constitutions and Bylaws of the Society(ies) for which I am applying. Further, I hereby affirm that I have no physical, mental, or emotional condition which would impair my ability to provide an acceptable standard of medical care. I understand that submission of false or fraudulent information may result in denial of membership or expulsion from the Society(ies).

I hereby release, and hold harmless from any liability or loss, the Society(ies) for which I am applying, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any and all individuals, organizations, and agencies or their authorized representatives from any liability concerning information provided about my professional competence, ethical conduct, character and other qualifications for membership.

Date: _____ Applicant's Signature: _____

The undersigned officer of the Denver Medical Society, having fully considered this application and appropriate supporting documents, recommends the following action:

Accepted _____ Rejected _____ Signature: _____ Date: _____