# 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 Date you will begin practice (if applicable) website

Practice Type: _____ private practice

_____ employed Name of Employer ______________________________

_____ other (describe) ______________________________

Member of medical "business" organization such as IPA, ACO, PHO, MSO ____ Yes ____ No If yes, name of organization: ______________________

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: ______________________ Specialty: ______________________
Date Issued Number

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

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

SPECIALTY BOARD CERTIFICATION(S): ________________________________________________________________

Certifying Board(s)

_______________________________________________________________________________________________

Original Date(s) of Certification Recertification Date(s) Expiration Date(s)

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: ______________________________________________

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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: ________________________