Practice Manager Application

First name | MI | Last name

Suffix (e.g. Jr., MD, MBA) | Title

Practice Name

Address ☐ Work ☐ Personal

City | State | ZIP

Email

( ) Business phone | ( ) Business fax

( ) Home phone | Year started in medical practice management | Year of birth

Highest education level completed:
☐ High school ☐ Associate ☐ Bachelor's ☐ Master's
☐ Doctorate ☐ MD ☐ DO ☐ JD ☐ RN ☐ Other

Gender:
☐ Male ☐ Female

Select your membership

☐ A physician at your practice IS a member of CMS/ISMS $99
☐ A physician at your practice is NOT a member of CMS/ISMS $395

Please list the name(s) of the physician(s) at your practice that is/are member(s) of CMS/ISMS

Payment Charge my credit card (check one)

☐ Visa ☐ MasterCard or ☐ Check enclosed (payable to Chicago Medical Society)

Card number

Expiration date | Card Code (3 digits on back of card)

Billing Address (if different from above)

City | State | ZIP

Name on card

Cardholder's signature | Date

Practice Manager Section

What is the number of physicians in your practice? _____

What type of medical practice is your organization?

☐ Single-specialty

☐ Multi-specialty primary/special care

☐ Multi-specialty care only

☐ Multi-specialty primary care only

☐ Not applicable

What is your practice's single specialty?

Three ways to join

1 **Phone:** Call 312.670.2550
8:30am — 4:30pm Monday — Friday

2 **Fax:** Send your completed application with credit card information to 312.670.3646

3 **Mail:** Return your completed application and check or credit card payment to:

Chicago Medical society
Attn: Membership Department
515 N. Dearborn St.
Chicago, IL 60654

Due to federal communication regulations, it is necessary for CMS to obtain signed written consent to distribute some information via fax and e-mail. Please note CMS does not sell or make available to the public its membership lists and will be providing information such as promotions, seminars and publication discounts available to members. Please sign below to receive communications via fax and e-mail.

Signature | Date