Illinois State Medical Society

2015 Membership Application

_____ County Medical Society
Your County Name

Check one:

☐ Physician ☐ *1st yr ☐ *2nd yr
☐ *3rd yr ☐ *4th yr ☐ Resident
☐ Student (* Year in practice)

PERSONAL DATA

Last:_____ First:_____ Middle:_____ ☐ MD ☐ DO
(Entire name should be as shown on medical license)

DOB_____ ☐ Male ☐ Female
mm/dd/yy

_____ _____ _____
Full Name of Medical School | Location of school | Graduation Year

_____ _____ _____ _____
IL State License Number | First Year of Medical Practice - Date | Primary Specialty | Sub-specialty

Practice Type(Check all that apply):

☐ Group ☐ Solo ☐ Academic ☐ Medical Research ☐ Administrative ☐ Employed ☐ Other _____

ADDRESS/COMMUNICATIONS INFORMATION (Please check the preferred address for ISMS correspondence)

☐ Primary Office Street/PO Box _____

City/State/Zip _____

☐ Home Street/PO Box _____

City/State/Zip _____

Practice/Group Name: _____

Email: _____

Office Phone: _____

Office Fax: _____

Home Phone: _____

Home Fax: _____

Office Manager: _____

Consent to Fax/E-mail: ☐ **Yes** ☐ **No**

Due to the federal communication regulations, it is necessary for ISMS to obtain written consent to continue distributing some information via fax and e-mail. By checking the box above and providing your fax number and e-mail address, you agree to receive from the association and its affiliates promotional notices or solicitations of the availability of goods or services and opportunities related to the practice of medicine. Please note ISMS does not sell or make available to the public its membership lists and will be providing the same type of communications as in the past such as HIPAA or other CME seminars and publication discounts available to members. You may opt out at any time by fax (312)782-0554 or e-mail membership @isms.org.

RESIDENCY/FELLOWSHIP INFORMATION

	Residency	Fellowship
Program Name	_____	_____
State	_____	_____
Year Completed	_____	_____

Help Us Say Thank You

If you are joining ISMS at the suggestion of a current ISMS member, we would appreciate the opportunity to say thank you. Please indicate the ISMS member who referred you.

_____
(Name of the ISMS Member)

AFFILIATIONS

Hospital Affiliation_____

Hospital Affiliation_____

Please submit application to:
Membership Services Department or fax: 312-782-0554
Illinois State Medical Society
Suite 700, 20 North Michigan Avenue
Chicago, IL 60602

You're better off! isms

Please Fax to: Membership Department 312-782-0554

With your credit card or EFT draft information below, we can process your membership application. Resident physicians, students and physicians in their first four years of practice also receive significant discounts ranging from 20% to 80% off the regular dues amount. Please contact ISMS or your county medical society for further information.

DUES SUMMARY

County (see below)	$_____	Required
ISMS	$ 570	Required
IMPAC	$ 200	
Total	$ _____	

MEMBERSHIP PAYMENT OPTIONS (please select one):

Annual Payment

☐ ISMS + County $ _____
☐ ISMS, County + IMPAC $ _____

Monthly Continuous Membership

☐ ISMS + County ÷ 12 months $ _____
☐ ISMS + County + IMPAC ÷ 12 months $ _____

(withdrawn on the 10th of each month)

PAYMENT INFORMATION

Please Check One:

1) ☐ Visa ☐ Mastercard ☐ American Express **1A)** ☐ Personal Credit Card ☐ Corporate Credit Card

Total: $_____ Expiration Date:_____/_____ CVV(3 or 4 Digit Security Code): _____

CC# _____- _____- _____- _____

2) ☐ Checking/Savings Account

Name of Bank:_____

Routing Number: _____

Account Number: _____

PLEASE NOTE: The deposit of a group's check or ACH payment does not confer membership status to the prospective physician. ISMS membership is contingent upon verification of the criteria set forth in the ISMS bylaws.

Signature: _____ Date: _____

Physician Dues Approximation Guide

ISMS full regular dues = $570; plus county medical society dues ($) listed below. If your county is not listed below the dues amount is $0.

Bond - $90	Henry/Stark - $25	Livingston - $75	Ogle - $20	Winnebago - $395
Boone - $100	Iroquois - $25	Logan - $75	Peoria - $415	
Champaign - $120.50	Jackson - $100	Macon - $200	Pike - $25	
Christian - $20	Jefferson/Hamilton- $150	Macoupin - $100	Randolph - $20	
Clinton - $100	Jersey/Calhoun - $50	Madison - $250	Rock Island - $395	
Cook - $395	Kane - $325	Marion - $50	St. Clair - $350	
De Kalb - $41.50	Kankakee - $180	Massac - $25	Sangamon - $285	
Du Page - $375	Kendall - $50	Mc Donough - $120	Tazewell - $100	
Edgar - $20	Knox - $175	Mc Henry - $250	Union - $12.50	
Franklin - $125	Lake - $325	Mc Lean - $240	Vermilion - $100	
Fulton - $80	La Salle - $75	Mercer - $25	Will/Grundy - $350	
Greene - $10	Lee - $100	Montgomery - $100	Williamson - $50	

Membership Application and Qualification Questions

Members abide by the ISMS Code of Medical Ethics and the bylaws of the Society. 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 a full explanation on a seperate *sheet of paper.*

Yes	*No*	
☐	☐	1. Have you ever been convicted of fraud or a felony?
☐	☐	2. 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 imposed sanctions or conditions.
☐	☐	3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

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).

The foregoing information is true and complete: Signature _____ Date _____