Illinois State Medical Society

CMS CHICAGO MEDICAL SOCIETY

2018 Resident/Fellow Membership Application

CMS and ISMS waive dues for residents and fellows.

Personal Information

Last Name (as shown on medical license) | First Name | Middle | MD DO

Home Address | City | Zip

Primary Email | Personal Email (if different from primary) | Male Female

Primary Phone | Cell Phone (if different from primary) | Social Security Number

Birth Date (mm/dd/yyyy) | Medical School Name | Graduation Year

IL State License # | Primary Specialty | Secondary Specialty

Professional Information

Residency/Fellowship
Program Name
State / Projected Completion Date
Transitional Medical Graduate – Has graduated from a U.S .accredited medical school or international equivalent but not yet secured a medical residency in the U.S.
Medical School Name
Location / Graduation year (2014-current)

Membership Application and Qualification Questions

Members abide by the bylaws of the Society and the ISMS Code of Ethics. 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 full information.***

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.

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Signature Date

Due to the new federal communication regulations, it is necessary for ISMS and CMS to obtain signed written consent to distribute some information via fax and e-mail. By Completing and Submitting this Application, you agree to receive from the association and its affiliates notices of the availability of goods or services and opportunities related to the practice of medicine. Please note ISMS or CMS do not sell or make available to the public its membership lists and will be providing the same type of promotions as in the past such as HIPAA or other CME seminars and publication discounts available to members.

	Yes	**No**
Consent to Fax/Email:	☐	☐

MAIL: Membership Department Chicago Medical Society 515 N. Dearborn St. Chicago, IL 60654

EMAIL: cms@cmsdocs.org

FAX: 312-670-3646