



## Membership Application

Please Return Application to:  
 Capital Medical Society, 1204 Miccosukee Road, Tallahassee, FL 32308  
[rcarlin@capmed.org](mailto:rcarlin@capmed.org)  
 Please attach a copy of your CV.

Question	Answer
Full Name	
FL Medical License #:	
NPI#:	
Date of Birth:	
Spouse's Full Name:	
Practice/Group Name:	
Practice/Group Administrator:	
Practice/Group Administrator email address:	
Practice Type:	<input type="checkbox"/> Solo <input type="checkbox"/> Employed <input type="checkbox"/> Medical Student <input type="checkbox"/> Group <input type="checkbox"/> Government Based <input type="checkbox"/> Academic <input type="checkbox"/> Other
Primary Specialty:	
Secondary Specialty:	
Please provide both addresses for our business use only. Do you prefer to receive mail at:	<input type="checkbox"/> Home <input type="checkbox"/> Office
Office Address:	
Office City/State/Zip:	
Office Phone:	
Office FAX:	
Office Email Address:	
Home Address:	
Home City/State/Zip:	
Home Phone:	

Cell Phone:	
Personal Email Address:	
Medical School/Degree/Date:	
<p><i>Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. 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.</i></p>	
Have you ever been convicted of a felony or fraud?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 other imposed sanctions or conditions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><i>I am aware that the 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></p> <p><i>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).</i></p> <p><i>The foregoing information is true and complete.</i></p>	<div style="border-top: 1px solid black; width: 100%;"></div> <div style="display: flex; justify-content: space-between;"> <span>Signature</span> <span>Date</span> </div>
<p><b>Please return application with a copy of your CV to:</b>  <b>rcarlin@capmed.org</b></p>	

Option to fill out on our website: <https://capmed.org/become-a-member/>