CAPITAL MEDICAL SOCIETY

Membership Application

Please Return Application to:
Capital Medical Society, 1204 Miccosukee Road, Tallahassee, FL 32308
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:	☐ Solo ☐ Employed ☐ Medical Student ☐ Group ☐ Government Based ☐ Academic ☐ Other
Primary Specialty:	
Secondary Specialty:	
Please provide both addresses for our business use only. Do you prefer to receive mail at:	☐ Home ☐ 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:	
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.	
Have you ever been convicted of a felony or fraud?	☐ Yes ☐ 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.	☐ Yes ☐ No
Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?	☐ Yes ☐ No
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 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
Please return application with a copy of your CV to: rcarlin@capmed.org	

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