Dear Doctor:

Thank you for your interest in joining the Hartford County Medical Association (HCMA) and the Connecticut State Medical Society (CSMS). We look forward to your participation in organized medicine. Your application will be processed by *Ryder Management & Consulting, LLC*, the management company of Hartford County Medical Associations. In order for us to process your membership application, please complete the following steps:

- Answer fully all questions on the **Application Information Sheet**.
- Calculate dues using the attached schedule and send a check payable to the Hartford County Medical Association with the completed application.

Once the completed application is received in this office, you will be eligible to access the many services offered to members.

Your acceptance in the CSMS is automatic with your membership in HCMA, as we share unified membership. We will advise CSMS once your application with HCMA has been approved. You will receive additional information directly from CSMS apprising you of the benefits and services available to you as a CSMS member; the information is also available at www.csms.org under “Member Benefits.”

Thank you for your interest in our organizations. **We urge you to consider membership in the American Medical Association. This application credentials membership for all three organizations.** If you need assistance, contact Cherie Niatopsky at cniatopsky.hcma@gmail.com. You may also phone at (203) 441-6142. We look forward to receiving your completed application and your participation in the HCMA, CSMS and the AMA.

Sincerely,

Mario Cohen, MD, FACOG
President, HCMA

Copy: Connecticut State Medical Society

HARTFORD COUNTY MEDICAL ASSOCIATION &
CONNECTICUT STATE MEDICAL SOCIETY
2019 DUES SCHEDULE

	FULL	1st Yr. PRACTICE*	2nd Yr. PRACTICE*
HCMA	**$390.00**	**$195.00**	**$390.00**
CSMS	**$620.00**	**$155.00**	**$620.00**
	$1,010.00	**$350.00**	**$1,010.00**
AMA	$420.00	$210.00	$315.00
	$1,430.00	$560.00	$1,325.00

***First or Second year of practice means newly out of residency/fellowship.**

NOTE: HCMA and CSMS SHARE UNIFIED MEMBERSHIP EFFECTIVE 4/5/01

PRORATED DUES SCHEDULE

Applications for membership received

On or before June 30th: Full dues amount

July 1st through October 31st: One-half dues amount

On or After Nov. 1st: Dues will not be assessed for the current year, however, please include payment for 2019 dues.

An applicant can not be approved for membership until the applicant's dues obligation has been met.

Include this page, a **check payable to the Hartford County Medical Association (or HCMA)**, along with a completed application to HCMA , c/o Ryder Management & Consulting, LLC, 250 Wolcott Road, Suite 3, Wolcott, CT 06716

Allocation of Dues

HCMA $_____
CSMS $_____
AMA $_____
TOTAL $_____

_____
«FirstName» «LastName», M.D./D.O.

APPLICATION INFORMATION SHEET

FOR MEMBERSHIP IN
HARTFORD COUNTY MEDICAL ASSOCIATION
CONNECTICUT STATE MEDICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION

Return to:
Ryder Management & Consulting, LLC
250 Wolcott Road, Suite 3
Wolcott, CT 06716
Telephone (203) 441-6142

NAME: _____
Last First Middle Initial MD/DO

DATE OF BIRTH: _____ National Provider Identifier #:_____ MALE ❑ FEMALE ❑

MARITAL STATUS: _____ SPOUSE'S NAME: _____

GROUP/PRACTICE NAME: _____

Type of Practice: Solo ❑ Partnership ❑ Hospital-Based ❑ Group ❑

NAME OF OFFICE MANAGER: _____

PRIMARY OFFICE ADDRESS: _____ _____
Street Telephone

_____ _____
Fax

_____ _____
City State Zip *E-Mail

BILLING ADDRESS (for dues or insurance premiums), *if different than Primary Office:*

_____ _____
Street Telephone

_____ _____
City State Zip Fax

HOME ADDRESS: _____ _____
Street Telephone

_____ _____
City State Zip Fax

Mailings To: Primary Office ❑ Dues & Insurance Premiums to Billing Address ❑ Home Address ❑

*Membership application will not be processed without an accurate email for HCMA communication.

PRACTICE INFORMATION

PRIMARY SPECIALTY: _____

SECONDARY SPECIALTY: _____

PRACTICE LIMITED TO: _____

ARE YOU BOARD CERTIFIED? *If yes, please list below*:

1. _____ _____ 2. _____ _____
Specialty Date Specialty Date

LANGUAGE CAPABILITY: _____ _____ _____ Sign: Y ❑ N ❑
(Other than English) First Second Other

EDUCATION AND TRAINING

(Please attach a statement explaining any gaps in chronology)

MEDICAL EDUCATION:

University	City & State	From/To	Degree

POST GRADUATE EDUCATION (*If additional space is needed, attach a separate sheet):*

Name of Institution	City & State	From/To	Specialty

PROFESSIONAL LIABILITY COVERAGE

Carrier Name	Effective Date	Expiration Date	Policy Number

HOSPITAL AFFILIATIONS

(Present Hospital/Medical Staff Privileges)

Hospital	From	Department	Type of Privileges
Primary			

CHRONOLOGY/WORK HISTORY

Please provide a CV *or list in chronological order, previous practices, hospital affiliations, leaves, etc., not required elsewhere in this application. If additional space is required, please use a separate sheet.*

Practice/Hospital Affiliation/Other	Location	From/To

GENERAL INFORMATION

Are you able to perform the essential functions of your medical practice with reasonable skill and safety with or without reasonable accommodation? Yes ❑ No ❑

(If you reply "yes" to any of the questions from below, please attach details.)

Y	N	
❑	❑	Have you ever been indicted in a criminal suit?
❑	❑	Have Medicare or Medicaid authorities ever brought documented charges against you?
❑	❑	Has your practice or training ever been interrupted?
❑	❑	Has your malpractice insurance ever been cancelled, non-renewed, restricted or special rated?
❑	❑	Has any suit for alleged malpractice been brought against you in the past five (5) years?
❑	❑	Have you or any malpractice carrier made an out-of-court settlement or paid a judgment of professional liability claim on your behalf in the past five (5) years?
❑	❑	Have you ever received notice that a report concerning you has been filed with the National Practitioner Data Bank?
❑	❑	Has disciplinary action been taken or is any pending against you by the board of medical licensure of any state or other jurisdiction?
❑	❑	Have you been convicted of a felony?
❑	❑	Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?
❑	❑	Have you voluntarily surrendered your license to practice medicine in order to avoid suspension, revocation or disciplinary action?
❑	❑	Have your narcotics licenses ever been suspended, revoked, or voluntarily surrendered, or has probation been invoked?
❑	❑	Have your privileges at any hospital ever been suspended, denied, diminished, limited, revoked or non-renewed?
❑	❑	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional association?

RELEASE OF INFORMATION

In consideration of Ryder Management & Consulting, LLC ("Ryder") processing my credentialing application, I grant permission and consent for Ryder and their agents, to obtain and verify information concerning my professional competence, character, and moral and ethical qualifications from all hospital administrators, members of hospital medical staffs, malpractice carriers, medical schools, medical associations/societies, and other persons or organizations. I hereby release Ryder, its officers, directors, employees and agents from any liability for actions performed in good faith in connection therewith.

I consent to the release by any person to Ryder and its agents of all information that may reasonably be relevant to an evaluation of my professional competence, character, and moral and ethical qualifications, including but not limited to any information relating to any disciplinary action, suspension or curtailment of surgical/medical privileges, and I hereby release any such person providing the information from any and all liability. I consent to the release by Ryder of the information contained in this Application Information Sheet, including any information obtained from any person pursuant to the preceding paragraph in connection therewith, to the Hartford County Medical Association and its subsidiaries and to any other third party authorized by me to receive such information for use in any credentialing activities undertaken by them.

I HEREBY AFFIRM AND REPRESENT THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF ALL STATEMENTS AND INFORMATION CONTAINED IN THIS APPLICATION INFORMATION SHEET ARE TRUE, CORRECT AND COMPLETE AS OF THIS DATE. I agree to inform Ryder promptly upon the occurrence of any event which results in a material change with respect to such statements or information.

_____ _____

Signature *Date*