APPLICATION INFORMATION SHEET

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

Return to:
917 Bridgeport Avenue
Shelton, CT 06484
Telephone (203) 513-2045

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 ❑

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?