2019 Membership Application
Physician Member

Applicant Information

(Entire name should be as shown on medical license)

Last Name ____ First Name ____ Middle ____ ○ MD ○ DO

DOB mm/dd/yy __/__/__ ○ Male ○ Female Medical School Name ____ Location of School ____ Graduation Year ____

IL State Medical License ____ First Year of Medical Practice ____ Primary Specialty ____ Sub-Specialty ____

Practice Type (Check all that apply) ○ Group ○ Solo ○ Employed ○ Academic ○ Medical Research ○ Administrative ○ Other ____

Address/Communications Information (Please check the preferred address for ISMS correspondence)

○ Primary Office Street/PO Box ____

City/State/Zip ____

○ Home Street/PO Box ____

City/State/Zip ____

Your County Name* ____

*If your home and office addresses are in different counties, indicate your **preferred** county for membership.

Preferred County Name ____

Practice/Group Name: ____

Email: ____

Please provide an email specific to you, not a general practice email.

Office Manager: ____

Office Phone: ____

Cell Phone: ____

Your contact information will be used only by ISMS and its affiliates - ISMS does not sell or share its membership list publicly. To opt out of receiving emails, contact us at **membership@isms.org** or call **800-782-4767, ext. 1900**.

Affiliations

Hospital Affiliation ____

Hospital Affiliation ____

Help Us Say Thank You

If you are joining ISMS at the suggestion of a current ISMS member, we would appreciate the opportunity to say thank you. Please indicate the ISMS member who referred you.

____
(Name of the ISMS Member)

Please submit application to:

Membership Services Department • Illinois State Medical Society • Suite 700, 20 North Michigan Avenue • Chicago, IL 60602

Fax: 312-782-2023 **Email: membership@isms.org**

ISMS membership now gives you a choice! This application is for ISMS only. If you are interested in membership in your county medical society, please go to the ISMS website at **www.isms.org/CountyList** for a complete roster of all Illinois county medical societies and their contact information.

Membership Payment

Please select preferred payment option.

With your credit card or EFT draft information below, we can process your membership application. Physicians in their first four years of practice also receive significant discounts off the regular dues amount.

Membership Category (Circle One)	◯ **Monthly Continuous Membership**		**OR** ◯ **One Annual Payment**
Regular membership	$45.13		$570
1st year in practice	$9.03	Save an additional 5% on Membership When Choosing Continuous Membership	$114
2nd year in practice	$18.05		$228
3rd year in practice	$27.08		$342
4th year in practice	$36.10		$456

Payment Information

All information will be kept secure and confidential.

1) Please Check One: ◯ VISA ◯ MasterCard ◯ American Express

1A) ◯ Personal Credit Card ◯ Corporate Credit Card

CC# Expiration Date: / CVV (3 or 4 Digit Security Code):

Signature: Date: / /

2) ◯ Checking/Savings Account

Name of Bank:

Routing Number:

Account Number:

Please Note: The deposit of a check or ACH payment does not confer membership status on the prospective physician. ISMS membership is contingent upon verification of the criteria set forth in the ISMS bylaws.

Signature: Date: / /

3) ◯ Check (make payable to ISMS and send to Illinois State Medical Society, Suite 700, 20 North Michigan Avenue, Chicago, IL 60602)

Conditions of ISMS Membership and Applications

Members pledge to abide by the ISMS Code of Ethics and Bylaws. Applicants and members must disclose to the ISMS legal division any fraud or felony convictions; actions taken regarding professional licensure, such as any revocation, suspension, probation, limitation, condition, or sanction; or discipline by any medical society or hospital medical staff. The ISMS is required to report certain professional review actions under state or federal law. The ISMS Code of Ethics and Bylaws can be found at **www.isms.org**.

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 in, probation or censure by, or suspension or expulsion from the medical society.

Signature: Date: / /

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