Illinois State Medical Society

2018 Resident/Fellow Membership Application

_____ County Medical Society
County Name

Check One:
☐ Resident
☐ Fellow

PERSONAL INFORMATION

Last Name (as shown on medical license) _____ First _____ Middle _____ ☐ MD ☐ DO

Home Address _____

City _____ State _____ Zip _____

Primary Email _____ Personal Email (if different from primary) _____

Primary Phone _____ Cell Phone (if different from primary) _____ Maiden Name (if applicable) _____

Birth Date (mm/dd/yyyy) _____ ☐ Male ☐ Female

Medical School Name _____ Graduation Year _____ Country _____

IL State License # _____ Primary Specialty _____ Secondary Specialty _____

Consent to Fax/Email: ☐ **Yes** ☐ **No**

Due to federal communications regulations, it is necessary for ISMS to obtain written consent to continue distributing some information via fax and email. By checking the box above and providing your fax number and email address, you agree to receive from the association and its affiliates promotional notices or solicitations of the availability of goods or services and opportunities related to the practice of medicine. Please note ISMS does not sell or make available to the public its membership lists. You may opt out at any time by faxing (312) 782-2023 or emailing membership@isms.org.

RESIDENCY/FELLOWSHIP OR TRANSITIONAL MEDICAL GRADUATE INFORMATION

☐ **Residency/Fellowship**

Program Name _____

State _____

Projected Completion Date _____

☐ **Transitional Medical Graduate** - I have graduated from a U.S. accredited medical school or international equivalent but have not yet secured a medical residency in the U.S.

Medical School Name _____

Location _____

Graduation year (2015-current) _____

ISMS Membership Department Fax: (312) 782-2023

RESIDENT MEMBERSHIP

☐ **YES!** I would like to join the Illinois State Medical Society and my local county medical society free of charge.

ISMS and your local county medical society waive dues for residents and fellows. You will receive your membership materials upon approval of your application. Should you have any questions, please contact your county medical society or the ISMS Membership Services Department at (800) 782-4767 ext. 1900 or membership@isms.org.

IMPAC DONATION

YES! I would like to make a voluntary contribution to the *Illinois State Medical Political Action Committee (IMPAC)* to support candidates for public office who defend our profession and promote sound medical policy.

☐ $20 (suggested contribution) ☐ Other amount _____

☐ Visa ☐ Mastercard ☐ American Express ☐ Check (made payable to *IMPAC)*

_____ _____ _____

Credit card number | Expiration Date (mm/yyyy) | CVV (3 or 4 Digit Security Code)

_____

Signature

IMPAC is a non-partisan political action committee dedicated to the support of candidates who are advocates on behalf of Illinois physicians and their patients. Contributions are not limited to the suggested amounts. IMPAC reports are filed with the State Board of Elections, 1020 S. Spring Street, Springfield, IL 62704. Voluntary membership contributions can be made with a corporate or personal check. Contributions to IMPAC are not deductible as charitable contributions for federal income tax purposes.

MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

Members abide by the ISMS Code of Ethics and the bylaws of the Society. To assist us in upholding these standards, please provide an answer to the following questions, sign and date. **If you answer yes to any of these questions, please attach a full explanation on a separate sheet of paper.**

Yes	No	
☐	☐	1. Have you been ever convicted of fraud or a felony?
☐	☐	2. 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 imposed sanctions or conditions.
☐	☐	3. Have you been the subject of any disciplinary action?

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 of 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

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

FAX: (312) 782-2023

EMAIL: membership@isms.org