APPLICATION FOR MEMBERSHIP

NASSAU COUNTY MEDICAL SOCIETY/NASSAU ACADEMY OF MEDICINE
& MEDICAL SOCIETY OF THE STATE OF NEW YORK

☐ First Year Practice ☐ Second Year Practice ☐ Resident ☐ First-Time Member ☐ Reinstatement

Name: _____ Birth Date: _____ Gender: _____

Office Address: _____

_____

Phone: _____

Residence Address: _____

_____

Cellphone/Residence Phone: _____ Personal Email: _____

Has your license to practice medicine ever been denied, suspended, or revoked by any government agency? ☐No ☐Yes
Have you ever been censored, suspended, expelled, or been disciplined by any professional Society, licensed health care facility, or other? ☐No ☐Yes
Have you ever been arrested or charged with any crime or violation of law other than traffic violation? ☐No ☐Yes
If YES to any of the above, indicate where, when and why: _____
Have you ever been a member of another county medical society? ☐No ☐Yes If so, where? _____
New York State medical license number: _____ Date issued: _____
Specialty: _____ Board Certified? ☐No ☐Yes Date: _____

If Board Certified, what Board(s)? _____ Medicare NPI Number: _____

RECORD OF MEDICAL EDUCATION AND PRACTICE

Medical College: _____ Graduation Date: _____

Internship/Residency/Fellowship Program(s):
Hospital/Facility: _____ Program: _____ Dates: _____
Hospital/Facility: _____ Program: _____ Dates: _____
Hospital/Facility: _____ Program: _____ Dates: _____

ATTESTATION:

In applying for membership, I agree to comply with the Bylaws, rules, and regulations of the Nassau County Medical Society, District Branch, and the Medical Society of the State of New York, and verify that the information presented is accurate:

Signature: _____ Date: _____

If you're interested in working on an NCMS committee, please email information@nassaucountymedicalsociety.org for further details.

TO BE COMPLETED BY NCMS:

SPONSORS: The undersigned active members of NCMS, having reviewed this application, recommend the applicant for election to membership:

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____

Report of the Board of Censors

I hereby recommend that this application be:

☐Approved ☐Rejected Signature: _____ Date: _____

☐Approved ☐Rejected Signature: _____ Date: _____

Nassau County Medical Society & Nassau Academy of Medicine

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Payment:

In order for us to process your application, a payment of $800 must be processed.

Please make all checks payable to the NASSAU COUNTY MEDICAL SOCIETY

and send them to our mailing address: 666 Old Country Road, Ste. 705
Garden City, NY 11530

OR

Please use the form below to provide your credit card information:

BILLING INFORMATION

Please complete all fields:

Address: _____

City, State, Zip: _____

Phone Number, Email: _____

CREDIT CARD INFORMATION:

Please complete all fields:

☐Mastercard ☐ Visa ☐Discover ☐American Express ☐Other

Cardholder Name: _____

Card Number: _____

Expiration Date (MM/YYYY): _____ Security Code: _____ Billing Zip: _____

Signature: _____ Date: _____

Please note that the completion of this form serves as authorization for the Nassau County Medical Society to charge your credit card to process the application, so long as the transaction corresponds to agreed application fee of $800.