FAX COVER SHEET & INSTRUCTIONS

PLEASE FAX THIS COVER SHEET
& MEMBERSHIP APPLICATION FORM TO:

FAX: (972) 810-4041

FROM: _____

DATE: _____

ATTN: COLLIN-FANNIN COUNTY MEDICAL SOCIETY
SUBJECT: CFCMS MEMBERSHIP APPLICATION FORM

COMMENTS:

OR

SCAN AND EMAIL TO: **SCB@COLLINFANNINCMS.COM**

OR

MAIL TO:

COLLIN-FANNIN COUNTY MEDICAL SOCIETY
2701 WEST 15TH STREET, SUITE 501
PLANO, TX 75075

Collin-Fannin County Medical Society
2701 West 15th Street, Suite 501
Plano, TX 75075
Phone: (469) 291-1954
Fax: (972) 810-4041

Collin-Fannin County Medical Society Membership Application

Membership Type: ☐ Resident ☐ First Year in Practice ☐ Active ☐ Military

BIOGRAPHICAL INFORMATION AND EDUCATION

Name:

Last | First | Middle | Suffix | Degree | Gender

☐ Office Address *(check if this is your preferred contact address)* | City | State | ZIP

Work Phone | Work Fax | Work Email

☐ Home Address *(check if this is your preferred contact address)* | City | State | ZIP

Home Phone | Home Fax | Home Email

Date of Birth | Place of Birth (Country) | Texas Medical License # | NPI #

Marital Status | Spouse's Name | If married, is spouse also a physician? ☐ Yes ☐ No

Practice Name | Specialty: Primary | Secondary

Medical School | Degree | Grad. Date | Residency/Fellowship (list most recent) | Specialty | Completion Date

PRACTICE TYPE AND EMPLOYMENT STATUS

☐ Direct Patient Care
☐ Direct Patient Care and Teaching
☐ Direct Patient Care and Research
☐ Administration (non-clinical)
☐ Full-Time Teaching (non-clinical)
☐ Research (non-clinical)
☐ Not in Patient Care
☐ Military
☐ Veterans Administration
☐ Not Employed
☐ Phys.-owned Prac.
☐ Direct Emp. by Hosp.
☐ Hospital NPHO
☐ Academic Inst.
☐ FQHC
☐ Retired
☐ Other

MEMBERSHIP QUALIFICATION AND AUTHORIZATION

	Yes	No
Have you ever had an application for membership in a medical society rejected?	☐	☐
Have you ever been convicted of a crime, other than a non-felony motor vehicle violation?	☐	☐
Has your medical license ever been revoked or suspended?	☐	☐
Have you ever been subjected to disciplinary action by any of the following?		
Board of Medical Examiners	☐	☐
County/State Medical Society	☐	☐
Hospital Medical Staff	☐	☐

I hereby apply for membership in the County Medical Society and Texas Medical Association and, if accepted, agree to abide by and be subject to terms and conditions of the Constitution and Bylaws of the Society and of TMA, and the Principles of the Medical Ethics of the American Medical Association. In order to process my application for membership, I grant permission and consent for you to obtain from any appropriate source all relevant information concerning my credentials and qualifications.

I understand that if my application for membership is denied by the Board of Censors, I have a right to appeal the denial to the County Medical Society pursuant to the *Hearings Procedure Manual*. I also understand that if my application for membership is denied, based on professional competence or conduct, the County Medical Society must report such a professional review action to the National Practitioner Data Bank through the Texas Medical Board within 15 days of the date that all due process rights have been exhausted.

I hereby release, and hold harmless from liability or loss, the County Medical Society, TMA, and any other CMS to which I transfer, their officers, agents, employees, and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above-named organizations, or their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character, and ethical qualifications to all hospitals, medical discipline boards, and medical licensure boards which request such information.

I also agree that biographical information will be disseminated in accordance with the policy and procedures established by the TMA Board of Trustees unless otherwise directed by me.

Physician Signature (required) _____ Date _____

APPROVAL OF BOARD CENSORS

The Board of Censors have had the above application under consideration, and: ☐ Approve *or* ☐ Disapprove on Date _____

Signature and Title

Note: Membership becomes effective when application has been approved and dues have been paid to the association.

PAYMENT INFORMATION

A physician becomes a member of the Texas Medical Association when joining the county medical society, since the county society is a component organization chartered by the association. $20 of TMA active membership dues is for a one-year subscription to *Texas Medicine*. **Dues paid to the county society and TMA are not deductible as charitable contributions for federal income tax purposes.** A portion of dues may be deductible as ordinary and necessary business expenses.

☐ Check (make payable to Texas Medical Association) ☐ Credit Card: ◯ VISA ◯ MasterCard ◯ Discover ◯ AMEX

☐ Automatic Dues Renewal (optional): By checking "Automatic Dues Renewal," I authorize TMA to retain my credit card information securely and to charge my credit card to pay my membership dues annually.

Name as it appears on card _____ Credit card number _____ Expiration date _____

Signature (required) _____

PLEASE SUBMIT PAYMENT WITH MEMBERSHIP APPLICATION TO:

Collin-Fannin County Medical Society, 2701 West 15th Street, Suite 501, Plano, TX 75075 **Phone: (469) 291-1954** **Fax: (972) 810-4041**