



Membership Application

Please include \$100 application fee
 Lee County Medical Society
 P.O. Box 60041
 Fort Myers, FL 33906-0041
 (239) 936-1645 /Fax: (239) 936-0533

PERSONAL INFORMATION (Please print or type)

Full Name (Print): Last _____ First _____ Middle _____

AMA Medical Education # _____ FL Medical License # _____ MD DO NPI # _____

Sex: Female Male Date of Birth: ___/___/___ Spouse's Full Name: _____

Place of Birth: _____ Foreign Languages Spoken in Office: _____

Practice/Group Name: _____ Website: _____

Office Manager: _____ Office Manager Email: _____

Practice Type: Solo Group Employed Government Based Academic Other

Primary Specialty: _____ Secondary Specialty: _____

Name of FMA/LCMS Member that recruited you: _____

MAILING INFORMATION

Please provide both addresses for our personal use. Do you prefer to receive mail at HOME OFFICE

Primary Office Address _____ City _____ Zip Code _____

Phone _____ Fax _____ E-Mail _____

Home Address _____ City _____ Zip Code _____

Phone _____ Fax _____ E-Mail _____

EDUCATION/ WORK HISTORY

INSTITUTION	LOCATION	DEGREE/SPECIALTY	DATES
Medical School			
Internship			
Residency			
Fellowship			
Other Post Graduate			

NAME PRACTICES IN CHRONOLOGICAL ORDER (Account for all time since Medical School. Use additional sheet if necessary)

Practice Name	Address	City, State	Dates
Practice Name	Address	City, State	Dates
Practice Name	Address	City, State	Dates

BOARD CERTIFICATION

1. Name of Board _____
Certified in _____ Date: _____
2. Name of Board _____
Certified in _____ Date: _____

HOSPITAL AFFILIATIONS

Hospital (Primary) _____ City _____
Hospital _____ City _____
Hospital _____ City _____
Hospital _____ City _____

REFERENCES

FOUR REFERENCES (Do not use Physicians in Lee County or relatives. Exception: If you practiced in Lee County for over five years then you may use four local references. Please see cover sheet.)

Name _____ Phone _____ Fax _____
Address _____
Name _____ Phone _____ Fax _____
Address _____
Name _____ Phone _____ Fax _____
Address _____
Name _____ Phone _____ Fax _____
Address _____

MEMBERSHIP IN MEDICAL ORGANIZATIONS: Have you ever been a member of the FMA? Yes No
Are you a member of your specialty organization? Yes No _____
Are you a member of the AMA? Yes No

COMMUNICATION CONSENT STATEMENT

This Communication Consent Statement is intended to fully comply with the Federal Trade Communications Commission Telephone Consumer Protection Act of 1991. I consent to receive communications sent via regular mail, email, telephone or fax by the Lee County Medical Society. I understand this Consent remains in effect as long as I remain a member of the Lee County Medical Society.

Signature _____ Date _____

MEMBERSHIP APPLICATION & QUALIFICATION QUESTIONS

Members abide by the AMA Principles of Medical Ethics and the bylaws of the Associations. To assist us in upholding these standards, please provide answers to the following questions, sign and date. If you answer yes to any of these questions, please attach full information.

- YES NO**
- Have you ever been convicted of fraud or a felony?
 - 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 other imposed sanctions or conditions
 - Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the 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 or probation or censure by, or suspension or expulsion from the medical society(ies). The foregoing information is true and complete.

Signature _____ Date _____

Lee County Medical Society Application

PHOTO INSTRUCTIONS

The LCMS will need a photo taken within the past year. The photo can be mailed with application or emailed to awilke@lcmsfl.org.

It will be used for the LCMS *Pictorial Directory, Bulletin* and website.

LCMS MEMBER RATE INFORMATION

\$395 Lee County Medical Society
\$50 Retired Physicians
\$25 LeePAC
\$115 Alliance
\$50 Public Relations Committee
\$50 McCourt Scholarship
Also Important
\$420 AMA
\$420 FMA
\$150 FMAPAC

MEDICAL SOCIETY USE ONLY

Committee on Ethical & Judicial Affairs:

1. _____ Membership (not) recommended, deferred.
2. _____ Membership (not) recommended, deferred.
3. _____ Membership (not) recommended, deferred.

Date

Chair, Committee on Ethical & Judicial Affairs

STATUS

Date application received _____

Date referred to Committee on Ethical & Judicial Affairs _____

Date approved by the Governors _____

Date approved by Society Membership _____

Date

Secretary of the Medical Society



Physicians Caring for our Community

PO Box 60041 • Fort Myers, FL 33906-60041
3805 Fowler Street, Ste 2 • Fort Myers, FL 33901
Tel: 239-936-1645 • Fax: 239-936-0533
www.lcmsfl.org

2010 Officers

President:
Craig Sweet, MD

President-Elect:
Shahid Sultan, MD

Secretary:
Richard Macchiaroli, MD

Treasurer:
Audrey Farahmand, MD

Past President:
Larry Hobbs, MD

Members-At-Large:
Rachid Aouchiche, MD

Howard Barrow, MD

Barry Blitz, MD

Stuart Bobman, MD

Jon Burdzy, DO

Valerie Dyke, MD

Douglas Henricks, MD

Mary Magno Mouracade, MD

Andrew Oakes Lottridge, MD

Executive Director
Ann Wilke

LEE COUNTY MEDICAL SOCIETY, INC.
WAIVER AND RELEASE OF LIABILITY

I, _____, having applied for appointment or
reappointment to the Membership of the Lee County Medical Society hereby
authorize the Committee on Ethical and Judicial Affairs, Board of Governors and
Officers of the Lee County Medical Society to contact any references listed by me on
my application for membership in the society or to any other physician, person, agency
or organization concerning my professional background, character, citizenship or
qualifications to be a member of the Medical Society; and, in so instructing the above
Boards, Officers, Committees and persons to make this investigation, I hereby agree to
hold them and any person or organization answering their inquiries about my
qualifications, education, experience, character and citizenship harmless from any
claims by me for any statements which they may make concerning me.

I agree that a copy of this release shall be sent to those references listed in this
application, together with a request for information concerning me and my
background, in order that the people writing references may be free to express their
honest opinions about my abilities as a physician and my reputation as a citizen to the
officers and officials of the Lee County Medical Society who are considering my
application for membership.

"I release and waive all claims related to the good faith furnishing or review of the
information described above."

SIGNATURE OF APPLICANT

DATE

WITNESSED BY