MEDICAL SOCIETY
www.brevardcountymedicalsociety.org

Membership application

BCMS was established in 1904 to serve as the voice of Medicine, to provide strong Government advocacy and to protect, improve and strengthen practice viability. BCMS remains as a trusted resource for our Physicians with strong advocacy.

Name: _____ Degrees: _____

Board Certifications: _____

Specialty: _____FL Med License Number_____

Office Address: _____

_____

Phone: Office _____ Cell: _____

Office Manager: _____ Phone: _____

Home Address: _____

Home Phone: _____ Email: _____

Preferred address for communication: □ Home □ Office

Payments can be made by □ Credit card or □ Check to "BCMS" or "Brevard County Medical Society" mailed to:

BCMS PO Box 126 Melbourne, FL 32903

Membership options:

□	Life membership: ***(one-time fee)***	$1500
□	Active Annual Membership	$200
□	Military/Governmental/ Administration	$200
□	Retired	$25

Credit Card: _____ CVV Code: _____ Expiration: _____

Name on card _____

Questions? Contact: Alicia Totty at 321 632 8481 exec@brevardcms.org or Dr. Piyush Joshi

1/1/2017

EDUCATION

Medical School: _____ Degree: _____Date:_____

Residency/Fellowship_____ Date_____

HOSPITAL AFFILIATIONS

1. Hospital (Primary)

_____

2. Hospital (Secondary)

_____

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?

□ **Yes** □ **No** 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.

□ **Yes** □ **No** 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