Columbia Medical Society
Application for Membership

Please Print or Type

Name: _____
Last *First* *Middle* *MD/DO*

Name of Group or Practice: _____

Office Address: _____
Physical address please *Street* *Suite* *City/State* *Zip*

Mailing Address: _____
Please specify if you have a mailing address that is different than your office physical address, e.g. PO Box

Preferred Email address: _____

Practice Website address: _____
Do you wish to have this web address linked to your name on the CMS website? yes____ no_____

Office hours: _____

Name/Telephone # of Office contact person: _____

Office Telephone: _____ **Office FAX:** _____

Cell Phone: _____ **Pager Number:** _____

For which membership category are you applying? (*check one*)

_____ **Resident member** ($20 annual fee)
_____ **Regular member/new** ($200 application fee)
_____ **Regular member/returning** ($290 annual fee)

Are you currently a member of the South Carolina Medical Association? ___yes ___no

Please indicate the method by which you prefer to be contacted by CMS:

___ Email ___FAX ___ Mail

Please indicate your preferred mailing address: ___ Office ___ Home ___ Office PO Box

Mail this completed form along with appropriate fee to:

Columbia Medical Society, 1214 Henderson Street, Columbia, SC 29201.

Please include your curriculum vitae and a recent photo and sign below. For questions, call 803.765.1498 or Email nancy@columbiamedicalsociety.org.

_____

Signature *Date*

Please complete the reverse side of this form.

Education & Training

Undergraduate school: _____ **Year graduated:** _____

Medical School: _____ **Year graduated:** _____

Residency: _____ **Year completed:** _____

Internship: _____ **Year completed:** _____

Fellowship: _____ **Year completed:** _____

Additional training: _____

Specialty: _____ **Sub-specialty:** _____

SC Medical License Number: _____ **Year obtained:** _____

Other states in which you hold a medical license: _____

Board Certifications *(include dates):* _____

Professional Association Memberships: _____

If you have been a member of another county medical society, please provide the name and location of the society and the years you were a member: _____

_____

Personal Data*

Home address: _____
Street *City* *State* *Zip*

Home Telephone: _____ **Spouse's Name:** _____

Date of Birth: _____ **Country of Origin:** _____

Gender: ___ Male ___ Female **Do you have children? ___ Yes ___ No If yes, what are their ages?** _____ **What are your hobbies/sports?** _____

_____

**Note: Personal information, Email address, cell phone and pager numbers are requested for use only by our office and will not be given to patients. Home address, telephone number and spouse's name will be provided to the Columbia Medical Society Alliance. If you have questions or concerns, please contact our office at 765.1498.*

Membership year begins January 1 and ends December 31. Annual dues for resident members are $20. Annual dues for regular members are $290 beginning with the second year of membership.The application fee for new regular members it is $200 and covers the first twelve months of membership. New regular members who join mid-year will have their second year's dues prorated accordingly. Dues are tax deductible as a business expense. According to the SCMA bylaws, membership in a county medical society is a prerequisite for membership in the South Carolina Medical Association.