Clark County Medical Society

Membership Application

Application Date: ______

Membership Type/Fees:
- ❑MD/DO $390
- ❑PA $150
- ❑Resident $ 50

Make Checks Payable To: **CCMS** *(no credit cards)*

Section I: To Be Completed by ALL Applicants

Name: ______ Last ______ First ______ MI

Title: ❑MD ❑DO ❑PA

Birth Date: ______ Birth Place: ______

Gender: ❑Male ❑Female

Practice Name: ______

Office Address: ______ Street ______ City ______ State ______ Zip

2nd Office Address: ______ Street ______ City ______ State ______ Zip

Mailing Address: ______ Post Office Box ______ City ______ State ______ Zip

Office Phone: ______ Fax: ______ Cell: ______ Email: ______

2nd Office Phone: ______ Fax: ______ Cell: ______ Email: ______

Office Manager: ______ Spouse's Name: ______

Home Address: ______ Street ______ City ______ State ______ Zip

Nevada License #: ______ Year Issued: ______ Home Phone: ______

Section II: To Be Completed by Physician's Assistant Applicants

Supervising Physician's Name: ______

Section III: To Be Completed by Physician (MD/DO) Applicants

Medical Education: ______ School Name ______ Address/City/State/Zip ______ Degree Earned ______ Date Graduated

Internship/PGY1: ______ Name ______ Address/City/State/Zip ______ Date Started ______ Date Completed

Residency: ______ Name ______ Address/City/State/Zip ______ Date Started ______ Date Completed

Fellowship: ______ Name ______ Address/City/State/Zip ______ Date Started ______ Date Completed

Date Started Nevada Practice: ______ # Years in Nevada: ______ Accepting New Patients: ❑ Yes ❑ No

Primary Specialty: *(Attach Copy of Certification)* ______ ABMS Listed Specialty ______ Board Cert Date

Secondary Specialty: *(Attach Copy of Certification)* ______ ABMS Listed Specialty ______ Board Cert Date

Primary Practice: ______

Other Board Certification: ______ Name of Board ______ Issue Date

AMA Member ❑ Yes ❑ No

Credentialed at the following hospitals:	❑ Boulder City	❑ North Vista	❑ Southern Hills	❑ St. Rose	❑ Sunrise	❑ Valley
	❑ Desert Springs	❑ Mountain View	❑ Spring Valley	❑ Summerlin	❑ UMC	

Within the last 5 years: *(For all "YES" answers, provide complete information on a separate sheet of paper)*

- Have you been convicted of a felony? ❑ Yes ❑ No
- Has your license to practice medicine in any jurisdiction been limited, suspended or revoked? ❑ Yes ❑ No
- Have you been the subject of any disciplinary action by any medical society or hospital staff? ❑ Yes ❑ No

Please list three Physician references with complete Name and Address for each:
(At least one local physician reference required, local references preferred)

	Physician Name	Address	City	State	Zip
1					
2					
3					

If elected into membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the Clark County Medical Society and the Nevada State Medical Association. I hereby release, and hold harmless from any liability or loss, the Clark County Medical Society, and the Nevada State Medical Association, 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 to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership.

Applicant's Signature (no stamps) Date

Mail completed application to: Clark County Medical Society
2590 E. Russell Road, Las Vegas, NV 89120
Phone: (702) 739-9989 / Fax: (702) 739-6345

Email photo (.jpg or .tiff) to: www.ccms@lvcm.com An electronic photograph is required to complete the application process. Please email the photograph or visit the CCMS office to have a digital photo taken.

For Office Use Only:

Reference Check	Date(s) Sent			Received
1) Reference Letter				
2) Reference Letter				
3) Reference Letter				

Action Items	Date Received/Completed
Photograph *(electronic only)*	
Payment	
AMA Profile	
ABMS Certification	
NBME License Verification	
Newsletter Announcement (issue)	
Approved by Board of Trustees	