Clark County Medical Society

Membership Application

Membership Type/Fees:

❑MD/DO $430 **(First Year Only)**

❑MD/DO $430 (**Active Limited**: Part time 20 hrs or less)

❑PA $150

❑Resident/Fellow Free **(1st Year) (2nd Yr – 50% of the annual membership fee, thereafter full membership dues)**

❑Student Free

❑MD/DO $860 ***Active - Full Time***

❑MD/DO $430 ***Active Limited – Part time***

Renewal & Reinstatements payments are sent to:
NSMA | 3700 Barron Way | Reno, NV 89511

CCMS Payment Options:

Check or Credit Card
(*See page 2 for option*)

Section I: To Be Completed by ALL Applicants

Name ______ Last ______ First ______ MI   Title: ❑MD ❑PA ❑DO

Birth Date ______   Birth Place ______   Gender ❑Male ❑Female

Practice Name ______

Office Address ______ Street ______ City ______ State ______ Zip

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

(If you have more than 2 offices please provide additional office location information on a separate sheet of paper)

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

Office Phone # ______ Office ______ Fax ______ Cell ______ Physician Email Address ❑ ***(I will accept CCMS Email notification)***

2nd Office Phone # ______ Office ______ Fax   Office Manager ______

Office Manager Email ______   Spouse Name ______

Home Address ______ Street ______ City ______ State ______ Zip

NV License # ______   Year Issued ______   Foreign Languages ______   Home Phone # ______

Section II: To Be Completed by Physician 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 ______ 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 Referrals ❑ 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

over ⇨

AMA Member ❑ Yes ❑ No

Credentialed at the following hospitals:

❑ Boulder City ❑ Desert Springs ❑ St. Rose-de Lima
❑ North Vista ❑ Mountain View ❑ St. Rose-Siena
❑ Southern Hills ❑ Spring Valley ❑ San Martin
❑ Summerlin ❑ Valley ❑ Centennial
❑ Sunrise ❑ UMC ❑ Other (please specify) ________________

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)*

	Physician Name	Address, City, State, Zip	Office Phone
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. **Any violation of the AMA principles of medical ethics or CCMS bylaws may be cause for sanction, suspension, or termination of membership in the CCMS at the discretion of its Board of Trustees, and potentially reportable to regulatory agencies where applicable.** 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 | LV, NV 89120
Phone: (702) 739-9989 / Fax: (702) 739-6345

Email photo (.jpg or .tiff) to: info@clarkcountymedical.org **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.

How did you hear about us?

❑ CCMS Website ❑ Colleague (please provide name) ________________	❑ Health Insurance Co. (please specify) ________________ ❑ Hospital	❑ Malpractice Insurance Co. ________________ ❑ Other (please specify) ________________

For Office Use Only:

Date Application Received:	*Reference Check*	*Date Received*	Action Items	Date Received/Completed
	1) Reference Letter		Photograph	
	2) Reference Letter		Payment	
	3) Reference Letter		AMA Profile	
	Member #		ABMS Cert.	
			NBME/NBOM Lic. Verification	
			Approved by BOT	

METHOD OF PAYMENT — Credit Card | Check

❑ Visa ❑ Master Card ❑ AMEX ❑ Discover

___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/ Exp. Date ___/___

______________________ Billing Address___________
Credit Card Signature Authorization *zip code*

Date ____________________

❑ Check Amount $___________ Check # ______________

Make check payable to: Clark County Medical Society or CCMS

Mail to: Clark County Medical Society
2590 E. Russell Road
Las Vegas, Nevada 89120

Fax: 702.739.6345