

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: Office Manager:

Office Manager Email: Spouse's Name:

Home Address: Street City State Zip

Nevada License #: Year Issued: Foreign Languages:

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

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)

1					
	Physician Name	Address	City	State	Zip
2					
	Physician Name	Address	City	State	Zip
3					
	Physician Name	Address	City	State	Zip

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 (<i>electronic only</i>)					
	Payment					
	AMA Profile					
	ABMS Certification					
	NBME License Verification					
Newsletter Announcement (issue)						
Approved by Board of Trustees						