ARLINGTON COUNTY MEDICAL SOCIETY MEMBERSHIP APPLICATION

Please indicate (X)	Annual dues (Invoiced annually)	Scope
	Active ($375)	Fee covers participation/meals at all regularly planned general membership meetings (4 minimum), White Coats on Call, quarterly newsletter, Caucus 1. **Fees for activities (e.g. golf/tennis, charity poker) are excluded.**
	Associate ($175)	Fee covers participation in White Coats on Call and quarterly newsletter. General membership meetings/meals and activities (e.g. Golf and Tennis/Annual Meeting) are not covered and will be charged extra.
	Courtesy/Retired ($37.50)	Fee covers participation in White Coats on Call and quarterly newsletter. General membership meetings/meals and activities (e.g. Golf and Tennis/Annual Meeting) are not covered and will be charged extra.

Name: ____________________ ______________________ **M** ____ **F** ____ **DOB** ___/___/_____
(LAST) (FIRST)

Office Information – will be listed on website with name and specialty
Address: ___________________________________ **Office Phone:** ____-_____-________
(street)
_______________________ ______ _________ **Website if available:** ____________________
(city) (state) (zip)

Personal Info – will not be shared

Married/Partner? Y N
Spouse/Partner Name: ____________________________

E-mail address: ___________________________________ **(How ACMS can inform/contact you)**

Home Address: ___________________________________ **Home Phone:** ____-_____-________
(street)
___________________ ______ ________ **Cel Phone:** ____-_____-________
(city) (state) (zip)

Year in which you began practice: ______ **Have you ever been convicted of a felony?**
Y N
Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?
Y N
Have you ever been the subject of any questionable practices by any medical society or hospital staff?
Y N

If you answered yes to any of the above questions, please provide a full explanation on a separate piece of paper.

EDUCATION AND LICENSE INFORMATION

Undergraduate degree from: __________________________________ **Year graduated:** ________

Medical School: ____ **Year graduated:** ________

Where and when:

Internship: ____

Residency: ____

Specialty: ____________________________________ **Board Certified: Y N date:** ___________

Subspecialty: _________________________________ **Board Certified: Y N date:** ___________

Virginia Medical License Number: __________________ **Date:** ___/___/_____

Hospital Staff Appointments: ______________________ **Attending** _______ **Courtesy** ________

Have you been or are you a member of any other State or County Medical Societies? Y N

If yes, please specify: ____

List/name 2 peers/colleagues as references (must be MD/DO):
__________________________ place of work/contact: __________________________
__________________________ place of work/contact: __________________________

I hereby certify that I have answered all of the questions contained in this application to the best of my knowledge and belief. If accepted for membership in this Society, I agree to be governed by the Constitution and By-Laws of the ACMS and to abide by the regulations prescribed therein or in the future added thereto, as well as to be bound by all present and future canons of ethics endorsed by the Medical Society of Virginia and the AMA. Furthermore, I do hereby authorize any person properly concerned herewith to make inquiry concerning any statements made herein.

(Photo Release) Furthermore, I grant to ACMS, its representatives and employees the right to take photographs of me and my property in connection with the events and circumstances relating to ACMS and its Foundation/charities. I authorize ACMS, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that ACMS may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content. I have read and understand the above.

Signature ___________________________________ Date _____________

Please email completed application to arlcoms@starpower.net *
Or TEXT pictures of both application pages to: 703-528-0888*
**we will email you a paypal invoice*

Or mail completed form with check payable to: ACMS, 4615 Lee Highway, Arlington, VA 22207

THANK YOU!