



**SANTA BARBARA COUNTY MEDICAL SOCIETY  
APPLICATION FOR MEMBERSHIP**



Please type or print in black ink - fill in all blanks. Additional sheets may be attached if necessary.  
If more than one office, please list additional office address on a separate sheet of paper.  
A California Participating Physician Application may be substituted for this membership application.

Date Received: \_\_\_\_\_

Revised: 6/2/05

**Name:(As shown on license) Last First Middle Other Name Used, If Any**

**Birthdate Place of Birth Ethnicity Gender Social Security #**

**Name of Corporation/Practice: Group Affiliation:**

**Primary Office: Street Address City ZIP Telephone # FAX # e-mail #**

**Residence: Street Address City ZIP Telephone # FAX #**

**SEND MAIL TO:**  Office  Home  Other Address:

**California License # Date Issued Date Expires Other State Licenses (State-Date Issued)**

Has your medical license in California or any other state ever been limited, revoked, suspended, or placed on a probationary status - or is such action pending?  Yes  No (If Yes, please provide details on a separate sheet of paper and attach to this application)

**Medical School Location Check Degree Date**  
 MD or  DO

**Internships: Institution Address State Dept. Dates**

**Residencies: Institution Address State Dept. Dates**

**Primary Specialty Secondary Specialty Special Interests**

**American Board Certification(s)/Date(s)**

**Medical Society Memberships: Organizations/Dates**

Please select/check the Practice Arrangement/Mode of Practice that best describes your practice:

- Solo/Small (1-4 phys. grp/corp)  Medium (5-150 phys. grp/corp)  Large (150-1,000 phys. grp/corp)  Very Large (1,000+)  
 Academic Practic  Hospital-Based Practice  Government-Employed Physician  Fully Retired  
 Administrative Medicine

By submitting this application, I hereby affirm that:

- if accepted, I will comply with the Constitution & Bylaws and Principles of Medical Ethics of the AMA, the CMA and the Component Medical Society. I further agree to recognize the authorized officers of these associations as the proper and sole authorities to interpret any doubtful point in professional conduct, and will at all times abide by and be governed by their interpretations.
- the information provided on this Application for Membership, and any addenda thereto is true, correct, and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application and /or termination of my membership. I understand and agree that acceptance of this application, application fees and/or dues does not constitute approval or acceptance of my membership, and grants me no rights or privileges of membership until such time as I receive notice of approval of my application and my acceptance letter.

Yes, this application includes membership with the American Medical Association.

**APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**APPLICATION FOR MEMBERSHIP**

<b>Postgraduate/ Fellowship:</b>	Institution	Address	State	Dept.	Dates
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<b>Specialty Training:</b> (Not Included Above)	Location		City/State	Type of Service	Dates
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<b>Teaching Appointments:</b> (Past/Present)	Name of Facility	Address	State	Faculty Rank	Dates
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<b>Hospital Affiliations:</b> (Current or Applied for)	Name & Location			Status	Dates
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<b>Previous Practice</b> (Activity since  Internship/ Residency)	Practice Name/Nature & Location				Dates
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<b>Military Service:</b> (optional)	Branch of Service	Rank			Dates
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<b>Membership in Professional/ Specialty Societies:</b>	Organization Name	Address			Dates
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<b>Peer References:</b> (or Sponsors)	Name	Mailing Address	Telephone #	# mos./yrs. known	
	1.				
	2.				
<hr/>					
<b>DEA Registration #</b>	Date Issued	Expiration Date	ECFMG#		
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<b>Professional Liability:</b>	Carrier	Address	Policy #	Limits	
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<b>Languages Other Than English</b>	Spoken by Physician			Spoken by Office Staff	
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<b>Marital Status(optional)</b>	Name of Spouse(optional)				

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IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE PROVIDE FULL DETAILS ON A SEPARATE SHEET.

- 1. Have your privileges at any hospital ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed, or is any such action pending?
2. Have you ever resigned from a hospital staff to avoid disciplinary action?
3. Have you ever been convicted of any crime (other than a minor traffic violation)?
4. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?
5. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, or subjected to probationary conditions by the Medical Board of California?
6. Have you been restricted or excluded or have you voluntarily or involuntarily relinquished eligibility to provide services by Medicare, Medi-Cal, or any public program, or is any such action pending?
7. Do you presently use any drugs illegally?
8. Have any judgments been entered against you, or settlements been agreed to by you within the last Seven (7) years, in professional liability cases, or are there any filed and served professional liability Lawsuits/arbitrations against you pending?
9. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

"I hereby affirm that the information submitted in this application and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or cancellation of my membership."

I hereby consent to the disclosure, inspection, and copying of information and documents relating to my credentials, qualifications, and performance by and between the state and county medical associations and other health care organizations (e.g., hospital medical staffs, medical groups, IPAs, health plans, medical societies, medical schools, professional associations, etc.) for the purpose of evaluating this application and, if accepted, my continuing membership. I hereby release all persons and entities, including the state and county medical societies, their employees and agents, and all persons and entities providing credentialing information to them, from any liability they might incur for their acts, omissions, and/or communications arising from this application or any membership decision, to the extent those acts, omissions and/or communications are protected by state and federal law. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Return Completed Application With: \$100 Application Fee & Press Photo

Santa Barbara County Medical Society
5350 Hollister Avenue, Suite A4
Santa Barbara, CA. 93111
PH: (805) 683-5333 FX: (805) 967-2871