Thank you for your interest in joining the Connecticut State Medical Society (CSMS).

To become an Associate Member of CSMS, a Physician Assistant must have:

- Endorsement from two (2) practicing physician members of CSMS
- Current NCCPA certification
- Connecticut state licensure as a Physician Assistant
- Current membership in good standing of the Connecticut Academy of Physician Assistants (ConnAPA)

In order for us to process your membership application, please complete the following steps:

- Answer fully all questions on the Application Information Sheet
- Provide documentation for NCCPA certification, licensure, and ConnAPA membership
- Provide a current CV
- Check the box at the bottom allowing CSMS to contact your references and verify your statements as written

Associate Membership must be approved by the CSMS Council. Once your application is approved, CSMS will notify you and provide information about the benefits and services available to you as an Associate Member of CSMS.

You will also receive an annual service fee invoice for $135.

If you have questions or need assistance, please contact the CSMS Membership Department at 203-865-0587 x103, or email dparilla@csms.org.

Thank you again for your interest in the Connecticut State Medical Society. We look forward to receiving your completed application and your participation in CSMS.

APPLICATION FOR ASSOCIATE MEMBERSHIP

CONNECTICUT STATE MEDICAL SOCIETY
127 Washington Avenue, North Haven, CT 06473
Tel: (203) 865-0587 Fax: (203) 865-4997

NAME: _____
Last First Middle Initial Suffix

DATE OF BIRTH: _____ GENDER: M☐ F☐ APPLICATION DATE: _____

NAME OF PRACTICE:_____

NAMES OF MD SPONSORS:

1) _____

2) _____

PRIMARY OFFICE ADDRESS: _____

CITY _____ STATE_____ ZIP_____-_____

PHONE (_____)_____EXT_____ FAX (____)_____

EMAIL ADDRESS_____WEBSITE_____

OFFICE 2 ADDRESS: _____

CITY_____ STATE____ ZIP_____-_____

PHONE (_____)_____ EXT_____ FAX(_____)_____

EMAIL ADDRESS_____

RESIDENCE ADDRESS: _____

CITY_____ STATE_____ ZIP_____-_____

TELEPHONE: (_____)_____

EMAIL ADDRESS:_____

PREFERRED MAILING ADDRESS: PRIMARY _____ OFFICE2 _____ RESIDENCE _____

PRIMARY
SPECIALTY:_____ SPECIALTY 2 _____ SPECIALTY 3 _____

UNDERGRADUATE EDUCATION: _____

CITY, STATE, COUNTRY: _____

YEAR GRADUATED: _____ DEGREE: _____

CERTIFICATION: _____

POST GRADUATE STUDIES:
NAME OF INSTITUTION CITY & STATE FROM/TO DEGREE

_____

_____

HOSPITAL AFFLIATIONS: (PRESENT HOSPITAL/MEDICAL STAFF PRIVILEGES)

Hospital Type of Privileges

_____

_____

_____

NCCPA#: _____ NATIONAL PROVIDER IDENTIFER (NPI): _____

CT LICENSE #:_____LICENSE DATE:_____ EXPIRATION:_____

YEAR YOU BEGAN PRACTICING IN THE STATE OF CT:_____

PROFESSIONAL MEMBERSHIPS: _____

_____

LANGUAGES SPOKEN FLUENTLY: _____

PROFESSIONAL LIABILITY INSURER: _____

HAS YOUR LICENSE TO PRACTICE EVER BEEN DENIED, SUSPENDED OR REVOKED BY ANY GOVERNMENT AGENCY? Y☐ N☐

HAVE YOUR HOSPITAL MEDICAL STAFF PRIVILEGES EVER BEEN RESTRICTED, SUSPENDED OR REVOKED? Y☐ N☐

HAVE YOU EVER BEEN REPORTED TO, OR INVESTIGATED BY, A COUNTY OR STATE MEDICAL ASSOCIATION OR A CRIMINAL COURT ON CHARGES OF UNPROFESSIONAL CONDUCT OR CRIMINAL BEHAVIOR? Y☐ N☐

If you answered "yes" to any of the above three questions, please attach details.

PLEASE NAME TWO MEDICAL ASSOCIATION MEMBERS WHO ARE WILLING TO WRITE LETTERS OF REFERENCE:

Print full name, phone and email if known

_____

_____

I GIVE THE CSMS CREDENTIALS COMMITTEE, PERMISSION, IF NECESSARY TO INVESTIGATE THE STATEMENTS, AS WRITTEN.

_____

Signature Date

THIS AREA FOR CSMS USE ONLY

PRESENTED TO THE COUNCIL MEETING AND APPROVED FOR MEMBERSHIP.

DATE: _____ _____MD

Secretary