Dear Doctor:

Thank you for your interest in joining the Fairfield County Medical Association (FCMA) and the Connecticut State Medical Society (CSMS). We look forward to your participation in organized medicine. In order for us to process your membership application, please complete the following steps:

• Answer fully all questions on the Application Information Sheet.

• Calculate dues using the attached schedule and send a check payable to the Fairfield County Medical Association with the completed application.

Once the completed application is received in this office, you will be eligible to access the many services offered to members. FCMA provides you with a number of low cost group insurance programs including life, health, dental, disability and accidental death and dismemberment.

Your acceptance in the CSMS is automatic with your membership in FCMA, as we share unified membership. We will advise CSMS once your application with FCMA has been approved. You will receive additional information directly from CSMS apprising you of the benefits and services available to you as a CSMS member; the information is also available at www.csms.org under “Products and Services.”

Thank you for your interest in our organizations. We urge you to consider membership in the American Medical Association. This application credentials membership for all three organizations. If you need assistance, contact us at (203) 513-2045. We look forward to receiving your completed application and your participation in the FCMA, CSMS and the AMA.

Mark S. Thompson
FCMA, Executive Director

Copy: Connecticut State Medical Society
<table>
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<tr>
<th></th>
<th>1st Year</th>
<th>2nd Year</th>
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<tr>
<td></td>
<td>FCMA</td>
<td>CSMS</td>
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<td>FULL</td>
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<tr>
<td></td>
<td>$420.00</td>
<td>$620.00</td>
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<tr>
<td>1st Year PRACTICE*</td>
<td>$210.00</td>
<td>$155.00</td>
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<td>2nd Year PRACTICE*</td>
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<td>$1040.00</td>
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*First or Second year of practice means newly out of residency/fellowship.

**PRORATED DUES SCHEDULE**

Applications for membership received:

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<tr>
<td></td>
<td>FCMA</td>
<td>CSMS</td>
<td>AMA</td>
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<tr>
<td>January 1 - April 30</td>
<td>$420.00</td>
<td>$620.00</td>
<td>$420.00</td>
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<tr>
<td>May 1 - September 30</td>
<td>$105.00</td>
<td>$155.00</td>
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<td>On or After October 1st.</td>
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Dues will not be assessed for the current year, however, please include payment for 2017 dues.

An applicant cannot be approved for membership until the applicant’s dues obligation has been met.

Send a check payable to the Fairfield County Medical Association, this page and a completed application to 917 Bridgeport Ave., Shelton, CT 06484-4679

Indicate Allocation of Dues

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<td>TOTAL</td>
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First Name  Last Name, M.D.
APPLICATION FOR MEMBERSHIP
Connecticut State Medical Society
Fairfield County Medical Association
917 Bridgeport Ave., Shelton, CT 06484-4679 • Tel: (203) 513-2045 • Fax: (203) 513-8036

Name: ____________________________________________________________________________________

Date of Birth: ______________ Gender: M___ F___ Application Date: ________________________

Marital Status: Married ___ Single ___ Widowed ___ Spouse’s Name ___________________________

Name of Practice: _______________________________________________________________________

Name of Practice Administrator: ____________________________________________________________

Practice is: Solo _____ Group _____ Hospital Based _____ Clinic/Walk In _____

Primary Office Address: ___________________________________________________________________

City ___________________________________________ State _____ Zip __________-________
Phone (_____)____________________ Ext. __________ Fax  (____)___________________________
Email Address ______________________________  Website _________________________________

Office 2 Address: _______________________________________________________________________

City ___________________________________________ State _____ Zip __________-________
Phone (_____)____________________ Ext. __________ Fax  (____)___________________________
Email Address ______________________________ Mobile Phone ____________________________

Residence Address: ______________________________________________________________________

City ___________________________________________ State _____ Zip __________-________
Phone (_____)____________________ Ext. __________ Fax  (____)___________________________
Email Address ______________________________ Mobile Phone ____________________________

Preferred Mailing Address: Primary ______ Office 2 ______ Residence ______

Primary Specialty: __________________________ ABMS Board Certified: Y____ N____ Eligible: _____

Specialty 2: _______________________________ ABMS Board Certified: Y____ N____ Eligible: _____

Specialty 3: _______________________________ ABMS Board Certified: Y____ N____ Eligible: _____

Medical School: ______________________________________ Year Graduated: _____________

City, State, Country: ______________________________________________________________________

Post Graduate Training: (Please specify Internship, Residency or Fellowship)

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<tr>
<th>Name of Institution</th>
<th>City &amp; State</th>
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<th>Specialty</th>
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over →
Hospital Affiliations: (Present Hospital/Medical Staff Privileges) Date: __________________________

Hospital Type of Privileges

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

CT License #: __________________________  License Date: _________________ Expiration: ____________

Year you began practicing in the State of Connecticut: ____________________________________________

National Provider Identifier (NPI) #: ___________________________________________________________

Language(s) spoken fluently: _________________________________________________________________

Use sign language: Y ____ N ____   Make house calls: Y ___ N ___

Professional Liability Insurer: _______________________________________________________________

Member of CSMS-IPA: Y ____ N ____ Pending: _________

AMA Member: Y ____ N ____ AMA ME#: _______________________________________________________

Has your license to practice medicine ever been denied, suspended or revoked by a 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 county medical association members who are willing to write letters of reference:

Print full name, address, phone and email if known

__________________________________________________________________________________________
__________________________________________________________________________________________

I give the Membership Committee, permission to investigate the statements, as written.

Signature  Date

__________________________
Chairman

THIS AREA FOR COUNTY USE ONLY

Approved for membership by the Membership Committee.

Date: ____________________________ ______________ M.D.

Chairman