

CT Infectious Disease Society Membership Application

Date: _____

FULL NAME & SUFFIX:

DATE OF BIRTH: _____ GENDER: M__ F__

PREFERRED MAILING ADDRESS: _____

CITY _____ STATE _____ ZIP _____ - _____

PHONE (____) _____ FAX (____) _____

PRIMARY EMAIL _____

MEMBERSHIP TYPE:

\$75 - Infectious Disease Physician ___ Non-Infectious Disease Physician ___ Pharmacist ___
APRN ___ Infection Prevention/Control Practitioner ___

\$30 - Resident/Fellow ___

INTEREST:

General Infectious Disease ___ HIV ___ Epidemiology ___ Research ___ Public Health ___
Health Care Administration _____

CURRENT STATE LICENSURE:

<u>PROFESSION</u>	<u>NUMBER</u>	<u>EXPIRATION</u>
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CURRENT NPI NUMBER: _____

ACADEMIC HISTORY:

MEDICAL SCHOOL: _____

LOCATION: _____

DEGREE: _____

DATES OF ATTENDANCE: _____

POST GRADUATE TRAINING: _____

LOCATION: _____

DEGREE: _____

DATES OF ATTENDANCE: _____

FELLOWSHIP: _____

LOCATION: _____

DEGREE: _____

DATES OF ATTENDANCE _____

Please make check payable to CIDS and mail application and payment to CIDS, 127 Washington Ave,
East Building 3rd Fl, North Haven, CT 06473. We can be reached at (203) 865-0587 ext 111.