



Personal Information

Last Name (as shown on medical license) _____		First _____	Middle _____	<input type="checkbox"/> M	<input type="checkbox"/> F
Spouse's Last Name _____		Spouse's First _____			
Home Address _____		City _____	State _____	Zip _____	
Home Telephone _____	Home Fax _____	Home E-mail _____		Birth Date (m/d/y) _____	
Place of birth _____	ME # if known _____	Maiden Name (if applicable) _____			
Social Security Number _____	Medical School Name _____		Graduation Year _____		

Illinois State Medical Society

- ✓ ISMS and the county medical societies both have a designated Medical Student Section
- ✓ Joining the ISMS and the county medical society offers additional membership benefits including:
- ✓ **Free stethoscope and Maxwell Quick Medical Reference pocket guide** with the ISMS and county four-year membership option
- ✓ **30% discount on Epocrates®** products
- ✓ News and publications such as *Illinois Medicine Express*, giving you the latest legislative alerts that impact your profession
- ✓ Informative Web sites, www.isms.org, and access to the members-only content including a medical legal library and one-stop grassroots legislative advocacy directory and **free** webinars
- ✓ Leadership opportunities with representation at the local, state and national levels
- ✓ Educational and professional programs including **MECO**, summer preceptorship program
- ✓ Networking with colleagues and mentors

Help Us Say Thank You

If you are joining ISMS at the suggestion of a current ISMS member, we would appreciate the opportunity to say thank you. Please indicate the ISMS member who referred you.

Name of the ISMS Member

Return Application and Payment

Please submit application to:
Membership Department or fax: (312) 782-0554
Illinois State Medical Society
Suite 700, 20 North Michigan Avenue
Chicago, IL 60602

ISMS Membership Department - Fax: (312) 782-0554

“Please work with my county medical society to facilitate the processing of my membership application.”

Please make check payable to Illinois State Medical Society and mail to:
Membership Department
Illinois State Medical Society
Suite 700, 20 North Michigan Avenue
Chicago, IL 60602

Please charge my credit card for the following:

- | | | |
|---|----------|-----------|
| <input type="checkbox"/> County medical society (see right box) | \$ _____ | Mandatory |
| <input type="checkbox"/> ISMS | \$ 5 | Mandatory |
| <input type="checkbox"/> AMA MSS | \$ 20 | Voluntary |

Total Amount to be charged \$ _____

or

With your credit card information below, we can process your membership application. You will receive your membership materials immediately upon approval.

Visa / Mastercard / American Express

Expiration Date

CVV

Signature

County Dues

Cook - \$10

DuPage - \$2

Kane - \$2

Lake - \$10

McHenry - \$2

Rock Island - \$2

Tazewell - \$5

*** If your county is not listed please note the county dues are \$0.**

Membership Application and Qualification Questions

Members abide by the ISMS Code of Medical Ethics and the bylaws of the Society. To assist us in upholding these standards, please provide answers to the following questions, sign and date. **If you answer yes to any of these questions, please attach full information.**

Yes No

1. Have you ever been convicted of fraud or a felony?
2. Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any imposed sanctions or conditions.
3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that information submitted in this application will be verified.

I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical society (ies).

The foregoing information is true and complete.

Signature

Date

Due to the new federal communication regulations, it is necessary for ISMS to obtain signed written consent to continue distributing *some information* via fax and e-mail. By providing the fax number and e-mail address and signing below, you agree to receive from the association and its affiliates promotional notices or solicitations of the availability of goods or services and opportunities related to the practice of medicine. Please note ISMS does not sell or make available to the public its membership lists and will be providing the same type of promotions as in the past such as HIPAA or other CME seminars and publication discounts available to members.

Fax this page to (312) 782-0554.

Printed Name

Signed Name

Fax Number

E-mail Address