MEMBERSHIP APPLICATION

CONNECTICUT DERMATOLOGY AND DERMATOLOGIC SURGERY SOCIETY
26 Sally Burr Road, P.O. Box 1079
Litchfield, CT 06759

PERSONAL INFORMATION

First Name:_____Middle Initial____Last Name:_____
Title (circle all that apply) MD DO PhD JD Cellphone:_____
Date of Birth:_____Marital Status: M S
If Married, Spouse's name:_____
County of Residence:_____Are you currently a member of the AAD_____
Home Address:_____
_____
Home Phone:_____Home Fax:_____
Email Address:_____
2nd Email Address_____
Where would you prefer receiving mail (circle one): home primary office satellite office
CT State Representative(s) and/or Senator(s) with whom you are acquainted:_____
_____
Please list your House District (if known):_____
Please list your Senate District (if known):_____
U.S. Congressman you are acquainted with:_____

PRACTICE INFORMATION

Number of years in practice:_____
Type of practice:_____
Primary office address:_____
Primary office phone:_____
Days in primary office (please circle): M T W Th F S
Satellite office address:_____
Satellite office phone:_____
Days in satellite office (please circle): M T W Th F S
Subspecialty:_____
Positions held (after medical school, not including training):_____
_____

HOSPITAL INFORMATION

Hospital for which privleges are held:_____
_____
How many years have you been on the staff:_____
Have you ever been denied privileges at any hospital?_____If yes, please state the reason:____
_____

Do you have a valid CT license?_____License number:_____
Has you license ever been revoked or suspended?_____If so, please give explanation:_____
_____

EDUCATION INFORMATION

College:_____Grad date:_____
Medical School:_____Grad date:_____
Residency:_____Completion date:_____
Fellowships:_____Completion date:_____
ABD certified?____Yes ____No If no, are you eligible? ____Yes ____No
Other certification? _____Yes _____No By whom:_____
Year Certified:_____Please attach a copy of this certification.
Medical License number:_____State Issued:_____Expiration Date:_____
Please list your scientific articles and other publications (attach additional sheets if necessary):
_____
_____
_____
_____

PROFESSIONAL/HONORARY AFFILIATIONS

Military service (dates and branch):_____
Hospital and University affiliations:_____
Other medical society memberships:_____
CSMS medical Society Membership: Yes_____ No_____
AAD Membership Yes_____No_____

MEMBERSHIP CATEGORIES

_____Regular Membership	$450.00
_____1ST Year in Practice	$175.00
_____2nd Year in Practice	$260.00
_____3rd Year in Practice	$350.00

I hereby submit my application for membership in the CDS. This completed Membership Application includes my professional qualifications. In accordance with CDS bylaws, I conform to the ethical standards embodied in the CDS Code of Ethics.

Signature:_____Date:_____