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Has you license ever been revoked or suspended?_____If so, please give explanation:_____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, attached are letters of recommendation from two CDS current active members attesting that I conform to the ethical standards embodied in the CDS Code of Ethics.

Signature:_____Date:_____