



TWIN MEMBERSHIP APPLICATION

(for two members joining together)

**Union County Medical Society
Medical Society of New Jersey**



Name _____ (Exactly as on NJ Medical License)

Medical Education Number _____ (If M.E. # unknown, leave blank)

NJ Medical License # _____ Date Issued _____ Birth Date _____ Sex _____

Primary Practice _____ Telephone # _____
(Group Name – if applicable)

_____ Fax # _____
(Street)

_____ E-mail Address _____
City, State, Zip

Medical Education _____
(School/Location) (Degree) (Year)

Specialty Areas – Primary _____

Board Certifications _____

Active Hospital Appointments _____

TWIN MEMBER’S NAME _____

Please answer the following. Attach a full explanation to any questions answered “yes”.

Have you ever been convicted of a felony crime? Yes ___ No ___

Has your license to practice medicine in any jurisdiction ever been suspended or revoked? Yes ___ No ___

Have you ever been the subject of disciplinary action by a medical licensing board, medical society or hospital staff? Yes ___ No ___

PAYMENT METHOD

2012 Dues for County & State = \$482.50 Each “Twin” Member (regularly \$945/member)

Check to UCMS _____ Visa _____ MasterCard _____ Amount _____ Card # _____

Expiration Date _____ CC_Billing Address _____ CVC (3 digits on back of card) _____

I hereby release, and hold harmless from any liability or loss, the County Medical Society and Medical Society of New Jersey, their officers, agents, Employees, & members for acts performed in good faith & without malice in connection with evaluating any application & my credentials & Qualifications, & hereby release from any liability any & all individuals & organizations, who, in good faith & with malice provide information to The above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character & other Qualifications form membership. Furthermore, I attest to the accuracy of information supplied on this application & understand that falsification of any information may result in denial or revocation of membership.

Applicant’s signature _____ Date _____

Mail to: UCMS, 1164 Springfield Avenue, Mountainside, NJ 07092

Tel: 908-789-8603

Fax: 908-789-8865

Email: ucms1164@verizon.net