Connecticut ENT Society, Inc.
P.O. Box 963
26 Sally Burr Road
Litchfield, CT 06759
Email: eyemaster2020@yahoo.com Website- www.ctentsociety.org

MEMBERSHIP APPLICATION

PERSONAL INFORMATION

First Name:_____Middle Initial____Last Name:_____
Title (circle all that apply) MD DO PhD JD Other:_____
Date of Birth:_____
Marital Status: M S If Married, Spouse's name:_____
County of Residence:_____
Home Address:_____
_____
Home Phone:_____Home Fax:_____
Email Address:_____
Where would you prefer receiving mail (circle one): home primary office satellite office
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):_____
CUS is all green- Newsletters and member updates will be emailed only. Please make sure you provide an address, which will not be given out.

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 and SURGICAL FACILITY INFORMATION

Hospital for which privileges 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:____
Surgical Facility where you perform your surgery_____

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Has you license ever been revoked or suspended?_____If so, please give explanation:_____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:_____
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:_____

ANNUAL DUES: $200.00

I hereby submit my application for membership in the CT ENT Society. This completed Membership Application includes my professional qualifications. I conform to the ethical standards embodied in the AMA Code of Ethics.

Signature:_____Date:_____