Cobb County Medical Society

Mail to:
Cobb County Medical Society, Inc.
114 Cherry Street, Suite D
Marietta, GA 30060
Attn: New Membership Application

Application for Membership

Name _____

Spouse _____ Birth _____

Office Address _____

Group Name

_____

Street Address *Suite Number*

_____ _____ _____

City *State* *Zip*

Telephone _____ *Fax* _____

Home Address _____

Street Address

_____ _____ _____

City *State* *Zip*

Telephone _____ *Cell or Pager* _____

Email Address _____

Specialty _____ _____

Primary *Secondary*

Board Certification _____

Georgia License Number _____ Expiration_____

Medical School Attended_____

Name

_____ _____

City *State*

Present Hospital Staff Privileges

Hospital	Type *Active, Associate, Courtesy, etc.*
_____	_____
_____	_____
_____	_____

Application continued on next page

Residences, Internships & Fellowships:

Name	Date
_____	_____
_____	_____
_____	_____

Disciplinary actions taken against Applicant by hospitals at which Applicant presently has staff privileges (please describe)

_____

_____

Disciplinary action taken against Applicant by other hospital(s) at which Applicant had staff privileges (please describe)

_____

_____

Disciplinary actions taken against Applicant by Composite State Board of Medical Examiners or other licensing body (please describe)

_____

_____

Any drug or alcohol abuse, past or present? (please describe)

_____

_____

Foreign Languages - please list:

_____

The undersigned applicant:

hereby certifies that all of the information contained in the application is true and correct;

hereby authorizes the **Cobb County Medical Society**, and its authorized representatives to consult with any and all persons and obtain any and all documents necessary to verify the accuracy of the information contained in this application;

hereby releases the **Cobb County Medical Society,** and its authorized representatives and all persons and organizations who provide information to the **Cobb County Medical Society** or its authorized representatives in accordance with this application from any liability arising out of the above described authorization actions;

hereby agrees to promptly notify the **Cobb County Medical Society,** in writing, in the event of a material change in any of the information provided by the Applicant in this application.

This _____ day of _____ 2019

_____

Applicant Signature