# APPLICATION FOR MEMBERSHIP

This application serves as my request for membership in the Lancaster County Medical Society (LCMS) and the Nebraska Medical Association (NMA). I hereby consent and authorize LCMS to use my application information that has been provided to the LCMS credentialing program, referred to as the Nebraska Credentials Verification Organization, in order to complete the LCMS membership process.

## PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial_____
Name as it appears on your License: _____
Office Name: _____
Office Address: _____ Zip: _____
Office Phone: _____ Fax: _____ Office Email:_____
Office Manager: _____ Office Manager Email: _____
Home Address: _____ Zip: _____
Home Phone: _____ Home Email:_____
Birthdate: _____ Gender:_____ Name of Spouse:_____
Languages Spoken for patient care: _____

## EDUCATION AND PROFESSIONAL INFORMATION

Medical School Graduated From: _____
Medical School Date of Graduation: _____ Degree (MD or DO) :_____
Residency Training Location: _____ Inclusion Dates: _____
Fellowship Location: _____ Inclusion Dates: _____
Nebraska Medical License Number: _____ NPI Number: _____
Primary Specialty: _____ Secondary Specialty, if applicable:_____
Referred By: _____

## MEMBERSHIP APPLICATION AND QUALIFICATION QUESTIONS

| Yes | No | (If you answer yes to any of these questions, please attached a letter giving full details for each.) |
|---|---|---|
| ☐ | ☐ | Have you ever been convicted of fraud or a felony? |
| ☐ | ☐ | Have you even been the subject of any disciplinary action by any medical society, hospital medical staff or a State Board or Medical Examiner? |
| ☐ | ☐ | Has any action, in any jurisdiction, even been taken regarding your license to practice medicine? This includes actions involving revocation, suspension, limitation, probation, or any other impose sanctions or conditions. |
| ☐ | ☐ | Have judgments been made or settlements required in professional liability cases against you? |
| ☐ | ☐ | Have you ever had an application for membership in a County Medical Society rejected or revoked? |

## BOARD CERTIFICATION

List Board Certification Status:_____
_____
_____

## RETURN INFORMATION

I certify that the information in this application is accurate and complete:

_____ _____
(Signature) (Date)

**Send completed application to:** Lancaster County Medical Society, 301 South 70th street Suite 340
Fax 1-844-361-2105 or email to admin@lcmsne.org