ID #_____

COLORADO SOCIETY OF EYE PHYSICIANS AND SURGEONS

APPLICATION FOR COLORADO SOCIETY OF EYE PHYSICIANS AND SURGEONS

Please complete all parts of this application. **A check payable to the Colorado Society of Eye Physicians and Surgeons in the amount of $750.00 must accompany the application.** If you are in academic medicine, or are in practice up to three years out of residency, or are retired from active practice, then you may be eligible for reduced dues and will be contacted by the CSEPS credentialing office upon review of your application.

Name: _____ ❑ Male ❑ Female
Last First Middle Degree

Primary Office: _____
Street Suite # City State Zip

Phone: (_____)_____ Fax: (_____)_____

E-mail address: _____ Web site address: _____

Type of practice: ____Solo ____Same Specialty Group ____Multi Specialty Group ____Faculty ____Administration _____Other (specify)

Present or anticipated local practice affiliation (e.g., name(s) of partners, group, etc.) and date you will begin active practice (if applicable): _____

_____

Home: _____ Phone: (_____)_____
Street Apt. # City State Zip

For my mailing address, please use: ❑ Office or ❑ Home

Date of Birth: _____ Place: _____ Spouse Name: _____
Month / Day / Year City / State / Country First Last

Colorado License: _____ _____ Other State License(s): _____ _____
Date Issued Number Date Issued / Number / State Date Issued / Number / State

Specialty: _____ Board Certification: _____
Certifying Board

_____
Certification Number Month / Day / Year Original Date of Certification Recertification Date Expiration Date

Medical Liability Insurance Carrier _____

MEDICAL SCHOOL: ECFMG # (Applicable to Medical Schools Outside of USA) _____

_____
Full Name of Institution / City / State Degree Mo / Yr

INTERNSHIP:

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

RESIDENCY:

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

FELLOWSHIP / PRECEPTORSHIP: (Circle one)

_____
Full Name of Institution / City / State Specialty Began Mo / Yr - Ended Mo / Yr

(OVER)

OTHER GRADUATE DEGREES:

Full Name of Institution / City / State	Specialty	Began Mo / Yr - Ended Mo / Yr

Foreign Language(s) Spoken: _____

Have you ever been convicted of a felony? Yes ☐ No ☐

Have your hospital medical staff privileges ever been refused, revoked, suspended or reduced? Yes ☐ No ☐

Has your license to practice medicine ever been denied, restricted, suspended or revoked? Yes ☐ No ☐

Are there any judicial or regulatory actions pending which could result in denial, restrictions, suspension, or revocation of your license to practice medicine? Yes ☐ No ☐

Have you ever been expelled from or denied membership in a state, or specialty medical society? Yes ☐ No ☐

Is there any pending review or disciplinary action with a state, or specialty medical society regarding your membership? Yes ☐ No ☐

If you answered yes to any of the above questions, please explain on a separate page and attach to this application.

Have you previously been a member of this specialty society: Yes ☐ No ☐ Date _____

If elected to membership, I agree to conduct myself professionally and personally according to the American Academy of Ophthalmology's Code of Ethics (http://www.aao.org/about/ethics/code_ethics.cfm) and to be governed and bound by the Constitution and Bylaws of the Colorado Society of Eye Physicians and Surgeons (CSEPS). Further, I hereby affirm that I have no physical, mental, or emotional condition which would impair my ability to provide an acceptable standard of medical care. I understand that submission of false or fraudulent information may result in denial of membership or expulsion from the society.

I hereby release, and hold harmless from any liability or loss, CSEPS, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any and all individuals, organizations, and agencies or their authorized representatives from any liability concerning information provided about my professional competence, ethical conduct, character, and other qualifications for membership.

Applicant's Signature: _____ Date: _____

The undersigned officer of the Society, having fully considered this application and appropriate supporting documents recommends the following action:

Accepted ☐ Rejected ☐ Signature: _____ Date: _____