SAN BERNARDINO COUNTY MEDICAL SOCIETY

1859 W. Redlands Blvd., Redlands, CA 92373
T (909) 273-6000 | F (909) 335-4800
www.sbcms.org

APPLICATION FOR RESIDENT MEMBERSHIP

PLEASE TYPE OR PRINT – FILL IN ALL BLANKS

Send me SBCMS' E-newsletter: ❑ Y ❑ N

Birthdate ______________ Gender Identification ❑ Male ❑ Female ❑ Trans ❑ Prefer not to disclose

First ______________________________ MI _____ Last ______________________________ ❑ MD ❑ DO

Home Address/City/State/Zip ____

Home Phone ______________________________ Cell Phone ______________________________

Email Address ______________________________ Spouse/Partner Name ______________________

SBCMS/CMA Membership Dues – Complimentary

(Membership for the entirety of residency program)

Medical School ______________________________ Date of MD/DO Degree ______________

MD/DO License # ______________ Date Issued ______________ ECFMG # ______________ Date Issued ______________

(TOP) ❑ I am an intern (011) ❑ I am a resident (012) ❑ I am a fellow (013)

Accredited Training Program ❑ ARMC (0207) ❑ Kaiser Fontana (0576) ❑ Pettis VA (0748)

❑ LLUMC (0238) ❑ LLUMC East (9185) Specialty ______________________

(ECD) Estimated Completion Date of postgraduate training in California ____________ (month/year)

Internship	From	Until
Residency	From	Until
Fellowship	From	Until

I authorize the SBCMS to request information appropriate to support my medical qualifications. I hereby release from any liability all individuals and organizations that provide information to SBCMS in good faith and without malice concerning my professional competence, ethics, character and other qualifications for membership, and hereby consent to such information. (Photographic reproductions of this statement and my signature shall be as fully effective as the original.) I certify that I am a house officer in good standing at the accredited training program indicated on this application.

Applicant Signature ______________________________________ Date ______________