



PALM BEACH COUNTY MEDICAL SOCIETY
3540 Forest Hill Blvd., Suite 101
West Palm Beach, Florida 33406
Phone 561-433-3940, Fax 561-433-2385
www.pbcms.org



MEMBERSHIP APPLICATION PHYSICIAN ASSISTANTS		
APPLICANT INFORMATION		
Name(First Middle Last):		
Degree/Certificate Designation (after name):		
Home Mailing Address 1:		
Home Mailing Address 2:		
City:	State:	ZIP Code:
Phone Number:		Home/Personal Fax:
Preferred E-mail:		Secondary E-mail:
Gender: Male / Female <i>(Please circle)</i>	Date of Birth:	Languages Spoken:
PROFESSIONAL INFORMATION		
Florida PA License Number:		NCCPA Certification Number:
Are you a member of FAPA? Yes / No <i>(Please circle)</i>		Are you a member of AAPA? Yes / No <i>(Please circle)</i>
Are you a member of any PA specialty organization? Yes / No <i>(Please circle)</i>		If so, which?
PA School Attended:		Year of Graduation:
PRACTICE INFORMATION		

Practice Name:		
Practice Address 1:		
Practice Address 2:		
City:	State:	ZIP Code:
Specialty of Practice:	Type of Practice: <i>(Please circle)</i> Solo / Group / Academic / Government / Hospital	
Number of Physicians in Practice:	Official Supervising Physician:	
Practice Main Phone:	Direct Line:	Cell Phone:
Pager:	Business Fax:	
MEMBERSHIP INFORMATION		
Would you like to be listed on our website? Yes / No <i>(Please circle)</i>		
Would you like to receive faxes from us? Yes / No <i>(Please circle)</i>	Preferred Fax number:	
Would you like to receive E-mails from us? Yes / No <i>(Please circle)</i>	Preferred E-mail address:	
If the answer was No to above questions, where should postal mailings be directed? Home or Practice <i>(Please circle)</i>		

Thank you for joining the Palm Beach County Medical Society.

We look forward to working with you.

PA Dues are **\$100**. Please mail application and check to PBCMS or

Join on line at www.pbcms.org -

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