Florence County Medical Society & Alliance Membership Application

Physician Name: _____

Practice Name: _____

Spouse's Name: _____ ☐ Check here if your spouse is a physician

Mailing Address (used for event notifications for you and your spouse):

_____

Physician Cell: _____ **Spouse's Cell:** _____

Physician's Email: _____

Spouse's Email: _____

***Billing address for dues, if different from mailing address above.** Please include the name/phone if there is an individual in your office responsible for paying your dues.

_____

If you are an employed physician, you can apply your CME allowance to FCMS membership dues.

McLeod Health and Hope Health will pay membership dues directly. If you prefer for your membership dues to be paid directly by your employer, please check the appropriate box below.

*If you are employed by MUSC, payment needs to be made by the individual directly to FCMS. The receipt can then be submitted to MUSC HR for reimbursement (FCMS will provide you with an appropriate receipt).

McLeod Health Employed Physician: _____ **Hope Health Employed Physician:** _____

☐ Please bill my employer automatically for my dues each year (you can request to stop this at any time).

MEMBERSHIP DUES (includes spouse if married) (Please check one)

☐ Practicing Physician / Physician couple - $210

☐ Resident Physician - No Charge

☐ Retired Physician - $110

☐ Widowed - $50

Credit Card Number _____

Exp. Date (MM/YY) _____ **CVV/CVC** _____ **Signature** _____

Make your check payable to FCMS and mail with this form to: PO Box 6556 • Florence, SC 29502