



INFECTIOUS DISEASES SOCIETY
of NEW JERSEY

Post Office Box 209
Convent Station, NJ 07961-0209
(973) 538-2354 • Fax (973) 539-9493
E-mail: idsocietyofnj@aol.com

MEMBERSHIP APPLICATION

Name _____ (Exactly as on NJ Medical License)
NJ Medical License # _____ Date Issued _____ Birth Date _____ Sex _____
Address _____ Telephone # _____
(Group Name – if applicable)
_____ Fax # _____
(Street)
_____ E-mail Address _____
City, State, Zip _____

Medical Education _____
(School/Location) (Degree) (Year) (Gender)

Specialty Areas – Primary _____

Board Certifications _____

Active Hospital Appointments _____

Please answer the following. Attach a full explanation to any questions answered “yes”.

Have you ever been convicted of a felony crime? Yes ___ No ___
Has your license to practice medicine in any jurisdiction ever been suspended or revoked? Yes ___ No ___
Have you ever been the subject of disciplinary action by a medical license board, Medical Society, or hospital staff? Yes ___ No ___

PAYMENT METHOD

2012 Dues = \$45.00

Please make check payable to: Infectious Disease Society of New Jersey

I hereby release, and hold harmless from any liability or loss, the Infectious Disease Society of New Jersey, their officers, agents, Employees, & members for acts performed in good faith & without malice in connection with evaluating any application & my credentials & Qualifications, & hereby release from any liability any & all individuals & organizations, who, in good faith & without malice provide information to The above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character & other Qualifications form membership. Furthermore, I attest to the accuracy of information supplied on this application & understand that falsification of any information may result in denial or revocation of membership.

Applicant's signature _____ Date _____

Mail to: IDSNJ, PO Box 209, Convent Station, NJ 07961-0209