



" In this great future, you can't forget your past "

McCune Smith-Cordice Medical Society, Inc. Membership Application Mission Statement

*To be a networking platform for minority
physicians and provide guidance and support
as they address their unique challenges and
those of their patients; through education,
community outreach, political influence and
advocacy, and mentorship.*

Applicant Information

Full Name: Rodriguez Carmen M.I. Date: 02/05/24
Last First M.I.

Home Address: _____
Street Address Apartment/Unit #

Phone: 800 Community Drive suite 215 418153180732 Email Cardcar@optonline.net
City State ZIP Code

Office Address: _____
Street Address Apartment/Unit #

Phone: 516-365-2100 Email CarmenRodriguez@live.com
City State ZIP Code

Preferred Mailing Address? Home Office

Education

Medical School: Sophie Davis Biomedical City College / Stonybrook Health Professional School: _____

Degree? MD DO Other

Medical Specialty: _____ Licensure Number/State: _____

Membership Selection and Dues

- Active Physician – \$200
licensed physicians (MD/DO), dentists, pharmacists in good standing and licensed to practice in NYS
- Affiliate – \$150
providers that no longer reside or practice in New York State but wish to remain affiliated with the society and participate in the activities of the society
- Residents and Fellows – \$75
graduates of recognized allopathic or osteopathic medical schools who are in training in accredited postgraduate programs in the tri-State area
- Students – \$50
enrolled in recognized allopathic or osteopathic medical schools in the State of New York who choose to participate in the activities of the society
- Retired – \$100
fully retired from the practice of medicine and will abide by all membership requirements of the society
- Emeritus membership –
all past officers who have been in good standing for at least five years and have made significant contributions to the Society
- Honorary -
Elected by the Society

Remit all payments via Zelle to Alan Butler @ 516-413-1599 or Venmo @ Alan-Butler-8

References

Please list two professional references.

Full Name: Dr Francine Hippolite Relationship: Colleague
 Company: _____ Phone: _____
 Address: _____

Full Name: Louis Auguste Relationship: _____
 Company: _____ Phone: _____
 Address: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to membership, I understand that false or misleading information in my application may result in my dismissal from the society.

Signature:  Date: 02/06/24

Submit applications to ??? (one of our personal emails or society emails??)

Thank you for considering membership to the McCune Smith-Cordice Medical Society.