

*Florida Society of Physical Medicine and Rehabilitation*  
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*President - Mitchell Freed MD, Orlando*  
*Vice President - Rigoberto Puente-Guzman MD, Gainesville*  
*Secretary – Matthew Infeld MD, Orlando*  
*Treasurer – Paul Kornberg MD, Tampa*

**Thank you for your interest in FSPMR.**

**Please complete the attached application and return it to Lorry Davis, Executive Director, at the address above. Make sure you include a copy of your curriculum vitae and a check to FSPMR for \$125.00 (application fee and dues for year in which you become a member).**

**Provided all is in order, you will be formally considered for membership at our next meeting.**

**Benefits of membership include:**

**\*meetings with continuing medical education**

**\*opportunity for networking in the state**

**\*monthly email/fax broadcasts keeping you “in the loop,” and more frequent email/fax broadcasts during Florida’s legislature**

**\*a link to organized medicine via representation on the Florida Medical Association’s Specialty Society Section**

**If you have any questions, please contact Lorry Davis, Executive Director, contact information above.**

**FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION**

**APPLICATION FOR MEMBERSHIP**

1. Name \_\_\_\_\_ Email: \_\_\_\_\_

2. Office Address \_\_\_\_\_ Telephone \_\_\_\_\_

\_\_\_\_\_ Fax \_\_\_\_\_

3. Place of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Nationality \_\_\_\_\_

4. Name of Spouse \_\_\_\_\_ Children \_\_\_\_\_

5. Specialty (1) \_\_\_\_\_ (2) \_\_\_\_\_

6. Practice: Private \_\_\_\_\_

Medical School Appointment \_\_\_\_\_

Hospital(s) \_\_\_\_\_

Other \_\_\_\_\_

7. Professional Education

Undergraduate \_\_\_\_\_ Dates \_\_\_\_\_

Graduate \_\_\_\_\_ Dates \_\_\_\_\_

Postgraduate \_\_\_\_\_ Dates \_\_\_\_\_

Other \_\_\_\_\_ Dates \_\_\_\_\_

8. Membership in Professional Organizations, Offices Held, Dates:

Florida Medical Association \_\_\_\_\_

AAPMR \_\_\_\_\_

Other \_\_\_\_\_

9. Recommended by (must be a current FSPMR member) \_\_\_\_\_

10. Florida Medical License #: \_\_\_\_\_

11. Signature \_\_\_\_\_ Date \_\_\_\_\_