



**MICHIGAN STATE
MEDICAL SOCIETY**
120 W. Saginaw, Lansing, MI 48823
msms@msms.org • www.msms.org
517-336-5762

State and County Medical Society Membership Application

Please PRINT or TYPE

FULL NAME _____ MD or DO
Last First Middle Initial

HOME ADDRESS _____
Area Code & Telephone Number

OFFICE ADDRESS _____
Area Code & Telephone Number

PRACTICE NAME _____
Office Fax Number

EMAIL ADDRESS _____ For mailing, please use (check one): **Office** address **Home** address

BIOGRAPHICAL DATA Sex: Male Female Birth Place _____ Maiden Name _____

Social Security # _____ Spouse's Name _____ Date of Birth _____
Month Day Year

Government Service (check one): Military National Health Service Beginning Date _____ Completion Date _____

EDUCATION (please complete or attach CV)

INSTITUTION	LOCATION	DEGREE	YEAR GRADUATED	
			Beginning	Ending
College/University _____	_____	_____	_____	_____
Medical School _____	_____	_____	_____	_____
SPECIALTY				
Residency _____	_____	_____	_____	_____
Residency _____	_____	_____	_____	_____
Fellowships _____	_____	_____	_____	_____
License: MI # _____	Date Issued _____	ECFMG # _____		
License held in other states/countries (list states or countries) _____				

PROFESSIONAL DATA Present Type of Practice (check appropriately):

OFFICE BASED: Solo Hospital Based Teaching Research Government
 Group Practice Name _____ Other (specify) _____

Specialty(ies) _____
 Board Certifications (list specialties & dates) _____

Present Hospital Appointments (list dates) _____
 Teaching Appointments (list dates) _____
 Previous Medical Society Membership (list dates) _____
 Specialty Society Memberships _____

Within the last five years, have you been convicted of a felony crime? Yes No If YES, please provide full information.
 Within the last five years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked? Yes No If YES, please provide full information.
 Within the last five years, have you been the subject of any disciplinary action by any medical society or hospital staff? Yes No If YES, please provide full information.

I agree to support the ST. CLAIR COUNTY MEDICAL SOCIETY Constitution and Bylaws, the MICHIGAN STATE MEDICAL SOCIETY Constitution and Bylaws, and the Principles of Ethics of the American Medical Association as applied by the AMA and the MSMS Judicial Commission.

Signature _____ Date _____

WHEN COMPLETED, please mail to MSMS or FAX to 517-336-5797. THANK YOU!

**ST. CLAIR COUNTY
MEDICAL SOCIETY**
2925 Riverside Drive
Port Huron, MI 48060-1897
810-987-1375 • bonnie@cmedis.com