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

MACOMB COUNTY MEDICAL SOCIETY
P.O. Box 62 • Yale, MI 48097
810-387-0364 • 810-387-0372 (fax)
mcms@msms.org

Do you work 20 hours or less per week? ☐ **YES** ☐ **NO**
Is your spouse a member of MSMS? ☐ **YES** ☐ **NO**
Is this the first year you have practiced in Michigan? ☐ **YES** ☐ **NO**

Please PRINT or TYPE

FULL NAME _____ (Last) _____ (First) _____ (Middle Initial) MD or DO (Circle One)

HOME ADDRESS, CITY & ZIP _____ _____ (Area Code & Telephone Number)

OFFICE ADDRESS, CITY & ZIP _____ _____ (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 _____ Date of Birth _____ (Month Day Year)

Maiden Name _____ Spouse's Name _____

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					

INTERNSHIP, RESIDENCY, AND FELLOWSHIPS	SPECIALTY	COMPLETION DATE

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 _____ Subspecialty _____
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 MACOMB 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 _____

AMA AMERICAN MEDICAL ASSOCIATION

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