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Macomb County Medical Society
 PO Box 551 • Lexington, MI 48450-0551
 Macombcms@gmail.com • www.macombcms.org
 Toll Free 877-264-6592

State & County Medical Society Membership Application

Member Status:

- 1st Year of Practice Post-Residency 2nd Year of Practice Post-Residency 3rd year of Practice Post Residency
- I have moved into Michigan, and this is my first year practicing in this state I work 20 hours or less per week
- I am currently in active military duty I am in full-active practice
- Male Female

First Name: _____ Middle: _____ Last Name: _____ MD or DO

Nickname or Preferred Form of Legal Name: _____ Maiden Name (if applicable) _____

Job Title: _____

Work Phone: _____ Work Fax: _____ Home Phone _____

Cell: _____ Email: _____

Office Address: Preferred Mail Preferred Bill Preferred Mail and Bill

Practice Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Address: Preferred Mail Preferred Bill Preferred Mail and Bill

Street: _____

City: _____ State: _____ Zip: _____

Please base my county medical society membership on the county of my (if addresses are in different counties): Office Address Home Address

Birth Date: ___/___/___ Birth Country: _____ MI Medical License# _____ ME# _____

License held in other states or countries: _____

Medical School: _____ Graduation Year: _____ ECFMG# _____

Residency Program: _____ Program Completion Year: _____

Fellowship Program: _____ Program Completion Year: _____

Hospital Affiliation(s): _____

Primary Specialty: _____ Board Certified Yes No Year _____

Secondary Specialty: _____ Board Certified Yes No Year _____

Marital Status: Single Married Spouse's First Name: _____ Spouse's Last Name: _____

Is your spouse a physician?: Yes No If yes, are they a member of MSMS?: Yes No

Within the last five years, have you been convicted of a felony crime?: Yes No If "yes", please provide full information on separate sheet.

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 on a separate sheet.

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 on a separate sheet.

I agree to support the 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:** _____

County Medical Society Use Only
 Reviewed and Approved

When completed, please mail to: PO Box 551, Lexington, MI 48450-0551 or email to macombcms@gmail.com