Macomb County Medical Society

PO Box 551 ♦ Lexington, MI 48450-0551 ♦ Phone 810-712-2546
Email: HLeach@macombcms.org ♦ www.macombcms.org

For MCMS Use Only
Date Received _____
Date Approved _____

Membership Application

Full Name (first, middle, last):_____ ☐ MD ☐ DO

☐ Male ☐ Female Maiden Name (if applicable) _____

Work Phone: _____ Work Fax:_____ Home Phone _____

Cell:_____ **Email:** _____

Office Address: ☐ Preferred Mail ☐ Preferred Bill ☐ Preferred Mail and Bill

Practice Name: _____

Street: _____

City:_____State:_____Zip:_____

Practice Manager Name:_____ Email: _____

Practice Website: _____

Home Address: ☐ Preferred Mail ☐ Preferred Bill ☐ Preferred Mail and Bill

Street: _____

City:_____State:_____Zip:_____

Birth Date: _____ Place of Birth:_____

MI Medical License #_____ NPI # _____

Licenses held in other states: _____

Medical School: _____ Graduation Year: _____

Residency Program: _____ Completion Year: _____

Fellowship Program: _____ Completion Year: _____

Hospital Affiliation(s):_____

Primary Specialty: _____Board Certified ☐ Yes ☐ No Year_____

Secondary Specialty: _____Board Certified ☐ Yes ☐ No Year_____

Within the last five years:

Have you been Convicted of a felony crime? ☐ Yes ☐ No If "yes", please provide full information on separate sheet.

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.

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 hereby apply for membership in the Macomb County Medical Society (MCMS) and agree to support the MCMS Bylaws.

SIGNATURE:_____**DATE:**_____

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