APPLICATION FOR MEMBERSHIP

MEDICAL SOCIETY OF SEDGWICK COUNTY
& KANSAS MEDICAL SOCIETY

DATE: ____________________

NAME: ____
First Middle Last MD/DO

PRACTICE NAME: ____

OFFICE ADDRESS: ____
Street Address City State Zip

OFFICE PHONE: ______________________________ OFFICE FAX: ___________________________

HOME ADDRESS: ____
Street Address City State Zip

HOME PHONE: ______________________________ CELL PHONE: ____________________________

EMAIL: ____

DATE OF BIRTH: __________ PLACE OF BIRTH: __________ SPOUSE: _____________________

FOR SOCIETY MAILINGS PLEASE USE MY: ( ) OFFICE ADDRESS ( ) HOME ADDRESS ( ) EMAIL ADDRESS

Would your spouse like to join or receive more information on the Medical Society of Sedgwick County Alliance? _____ Yes _____ No _____ Information Only

A CURRENT COLOR PHOTO MUST ACCOMPANY THIS APPLICATION. Please do not send a photo copy of a picture or a picture printed on copy paper. You may email a jpg image to katherinemurphy@med-soc.org if it is more convenient. This picture will be used on the public page of MSSC's web based physician finder and in the MSSC annual pictorial membership roster.

MEDICAL SCHOOL:
Institution: ____ MD or DO

____
Street Address City State Zip

Dates: ______________________

INTERNSHIP:
Institution: ____

____
Street Address City State Zip

Dates: ______________________

NOTE: This application will be considered by the Membership & Ethics Committee, published in the MSSC News and thereafter submitted for vote to the Board of Directors of the MSSC with the chairman's recommendation. Questions should be referred to the Executive Director, Medical Society of Sedgwick County, 1102 S. Hillside, Wichita, KS 67211, 683-7557. You may also contact Katherine Murphy, Membership Coordinator at 683-7670.

RESIDENCY:

Specialty: ____

Institution Name:____

____
Street Address City State Zip

Dates: ______________________

FELLOWSHIP:
Specialty: _______________________________

Institution Name:____

____
Street Address City State Zip

Dates: _______________________

PRACTICE HISTORY: (List chronologically. If additional space is required, please attach addendum.)

____
office, group or institution

____
Street Address City State Zip

Dates:_________________________

____
office, group or institution

____
Street Address City State Zip

Dates:_________________________

Last Hospital Affiliation: _________________________________

____
Street Address City State Zip

Dates: ________________________

Kansas Medical License #:_____________________ Date issued: __________________

Licenses held in other states:___________________________________

Wichita Hospital Staff Affiliations: ______________________________

Practice Specialty: ____
Do you limit your practice to this specialty? _____ Yes _____ No

Board certification: (name & date certified) ____________________________

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Previous county medical society memberships: (list names & dates)___________________________________

____

Previous state and national medical association memberships: (list names & dates)

____

Have you ever been under disciplinary action by any of these societies?
_____ Yes _____ No

Are you proficient in languages other than English? If yes, please list. ________________________

ECFMG #: (if applicable) ___________________________

DEA #:____

NPI #: ____

SSN #: ____

Have you ever had an application for medical licensure, hospital privileges or prescribing privileges denied?
_____ Yes _____ No

Have your medical license(s), your hospital privileges or prescribing privileges ever been limited, restricted, suspended, revoked or voluntarily surrendered?
_____ Yes _____ No

Have you had any professional liability claims filed against you?
_____ Yes _____ No

Have you served in the U.S. Military? If so, please enclose a copy of your discharge papers.
_____ Yes _____ No

Have you ever been convicted of fraud or felony?
_____ Yes _____ No

If you answered yes to any of the above questions, please include an explanation on a separate sheet and attach to this application.

PLEASE SEND COPIES OF TRAINING CERTIFICATES, BOARD CERTIFICATIONS AND MEDICAL LICENSES, AS WELL AS A COLOR PHOTO ALONG WITH THIS APPLICATION.

I hereby apply for membership in the Medical Society of Sedgwick County and the Kansas Medical Society.

I agree that the societies may make such evaluation of my professional qualifications to be a member, as they deem necessary. I will furnish to the society all information requested of me for such purpose, and if I have completed, signed and submitted a Medical Professional Application to Medical Provider Resources, I authorize release of a photocopy of that application and supporting documentation to these societies to be utilized in evaluating my application for membership. I agree the society may use this release to request information regarding my hospital privileges. Upon becoming a member, I agree to conduct myself professionally and personally according to the AMA Principles of Medical Ethics and the bylaws of the Medical Society of Sedgwick County and the Kansas Medical Society.

I hereby release and hold harmless from any liability or loss, the Medical Society of Sedgwick County, its members, agents and employees and the Kansas Medical Society for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications concerning my professional competence, ethical conduct, character and other qualifications for membership. This release shall not expire.

____ ____________________
Applicant's Signature Date

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