Medical Society of Delaware

900 PRIDES CROSSING, NEWARK, DE 19713 ▪ PHONE (302) 366-1400 ▪ FAX (302) 366-1354 ▪ EMAIL: MEMBERSHIP@MEDSOCDEL.ORG

APPLICATION FOR MEMBERSHIP

Membership Type: ☐ **Active** ☐ **Affiliate** ☐ **Associate**

To ensure proper credit through the Member Recruitment Incentive Program, please print the MSD member physician's name who encouraged you to join:

_____

Your Name _____ M.D. ____ D.O. ____
First Middle Last Maiden Name (if applicable)

Employer/Group _____ Office Phone _____
(Please indicate Parent Company Name. Note: May or may not be the same as DBA Practice Name below. Group memberships will be identified by this name.)

DBA Practice Name _____
("Doing Business As" Practice name may or may not differ from Employer/Group Name)

Office Address _____ Office Fax _____
(MSD must have office address on file if practicing.)

City _____ State _____ Zip _____

Physician's Preferred Email Address _____
(MSD will deliver important, timely information affecting your practice and the health care industry to this address)

Home Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell _____

MSD does, from time to time, send correspondence to both home and office, dependent upon the appropriate location for receipt. However, routine communications will be sent to the preferred address indicated below:

Preferred Mailing Address: ___ Home Address ___Office Address

MSD provides practice information tailored for office staff use. Please provide the following information:

Practice Manager _____ Email _____ Phone _____

BIOGRAPHICAL DATA

DATE OF BIRTH ___/___/_____ GENDER __Male __Female MARITAL STATUS: __Single __Married
MM DD YYYY

If married, spouse's full name _____
First M.I. Last

U.S. Citizen □ Yes □ No If no, please explain your status in the U.S. _____

Languages Spoken (fluently, in addition to English) _____

EDUCATION/TRAINING

Medical School _____ Graduation Year _____

Training	Hospital Name & Location	Specialty	Began (mo/yr)	Ended (mo/yr)
Internship				
Residency				
Fellowship				

(If you have additional training information to provide, please attach your Curriculum Vitae)

(Continued on other side)

Primary Specialty _____ Board Certification Expiration _____

(*Primary is defined as the specialty for which you devote the majority of your daily practice and by which MSD will identify you.*)

Subspecialty or other Specialty _____ Board Certification Expiration _____

Special Medical Interests _____

Interest in speaking to the Media/what topics? _____

DE Medical License _____ AMA Med Ed # _____ ECFMG Cert # _____ (If applicable)

PRACTICE TYPE

☐Private Practice **If Private Practice (check only one)**: ☐Solo ☐ Group (# physicians)

☐Employed (*defined as a practice which is not physician-owned)* ☐Government (such as State/Federal) ☐Corporate/Business

PRACTICE SETTING

☐Concierge Medicine ☐Direct Care ☐Hospitalist ☐Administration ☐Research ☐Teaching

☐Ambulatory Surgical Center ☐Clinic (FQHC/Free Standing/Charitable) ☐Free Standing Emergency

☐Hospital or Hospital System ☐Urgent Care ☐Medical Aid Unit ☐Locum Tenens ☐In Training

☐ **Other** (specify): _____

Current Hospital Affiliations/Year Affiliated _____

Current Teaching Affiliations/Year Affiliated _____

Current Medical & Specialty Society Memberships/Year joined _____

Previous State Medical Society Memberships/Year joined/Year lapsed _____

Are you the subject of any current or pending investigation with regards to clinical competency or ethical conduct as defined in 24 Del. Code, §1731? ☐ Yes ☐ No (*If yes, please explain. Your application will be held pending the outcome of the investigation.*)
§1731 can be found on the State of Delaware website: http://delcode.delaware.gov/title24/c017/sc04/index.shtml

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Those deemed eligible for active membership will possess a doctor of medicine/osteopathic medicine degree or recognized international equivalent and an unrestricted license to practice medicine and surgery in the State of Delaware (as defined by the Delaware Board of Medical Licensure and Discipline). Membership eligibility is based on good moral character, professional standing, and professional ethics, as well as conduct as defined in 24 Del C., 1731(b) of the Medical Practice Act and as Title 24, Chapter 17 of the Medical Practice Act may be amended from time to time. If approved for membership, I agree to conduct myself professionally and personally according to the principles of medical ethics of the American Medical Association and to be governed by the Bylaws of the Medical Society of Delaware (MSD). By signing this application and upon approval of my membership in MSD, I understand I will receive communications (via various means) from MSD as a member of the organization. Membership dues are prorated based on approval date.

Applicant's Signature _____ Date ___/___/___

By signing above I certify that I know, understand, and comply with all requirements for membership in MSD.

For office use only **Recruitment Code:** WEB **Membership Type:** _____ ☐ Accepted ☐ Declined

Application Received: ___/___/_____ Entered in Database: ___/___/_____ App Acknowledgement: ___/___/_____

To Committee _____/_____/_____ To Membership _____/_____/_____ Join Date ____/____/_____
Approval _____/_____/_____ Approval _____/_____/_____ Welcome Letter _____/_____/_____

Notes:_____

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