



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

CALHOUN COUNTY
 MEDICAL SOCIETY
 PO Box 278
 Battle Creek, MI 49016-0278
 269-660-0893 • Calhouncms@yahoo.com

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

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

