



Application for Membership
Monroe County Medical Society
and the Medical Society of the State of New York



MCMS, The Park at Allens Creek, 132 Allens Creek Road, Rochester, NY 14618 X (585) 473-4072

County and state membership is unified. Physicians may join the county society where they practice or where they reside.

Check if also applying to the AMERICAN MEDICAL ASSOCIATION (dues on reverse)

NAME _____ SOC SEC # _____
Last First MI Jr./ Sr.

HOME ADDRESS (H) _____
City State Zip

HOME TEL () _____ HOME FAX () _____

GROUP NAME (If applicable) _____ Group manager's Email _____

OFFICE ADDRESS (O) _____

Send mail to H O City State Zip

OFFICE TEL () _____ OFFICE FAX () _____

E-MAIL _____ DATE OF BIRTH _____ Male Female

MEDICAL SCHOOL _____ YEAR OF GRADUATION _____ MD DO

DATE OF COMPLETION OF RESIDENCY/FELLOWSHIP _____ OTHER DEGREES _____

CHECK IF WORKING FEWER THAN 20 HOURS/WEEK NAME OF SPOUSE _____

CURRENT HOSPITAL AFFILIATIONS (If none, please list any HMO affiliations and provide your CV.)

HOSPITAL/LOCATION	POSITION/SPECIALTY
_____	_____
_____	_____
_____	_____

NYS LICENSE # _____ DATE GRANTED _____ DATE ENTERED PRACTICE _____

BOARD CERTIFIED? _____ YEAR _____ SPECIALTY _____

WORKERS' COMP BOARD RATING _____ ECFMG # (If attended medical school abroad) _____

ARE YOU ACCEPTING NEW PATIENTS? Yes No

- Yes No Has your license to practice medicine ever been denied, suspended, revoked, or voluntarily surrendered?
- Yes No Have your privileges or employment at any health care facility or entity ever been denied, suspended, terminated, revoked or voluntarily surrendered?
- Yes No Have you ever been convicted of or pled guilty to any act that constitutes a misdemeanor or felony?

Have you ever been a member of this or any other county medical society? _____ County _____ When? _____

Is there a member we can thank for encouraging you to join? (Name) _____

PHYSICIAN'S ATTESTATION: *"In applying for membership, I agree to comply with the bylaws, rules and regulations of the county society, the district branch, and the Medical Society of the State of New York. In providing fax and e-mail information, I give the medical societies permission to send me news updates, important legal/legislative notices, seminar invitations, advertisements and web links."*

PLEASE CHECK HERE TO INDICATE AGREEMENT Signature _____ Date _____

Second Office _____

Second Office Phone _____ Second Office Fax _____