Saginaw County Medical Society
Resident Membership Application

PLEASE COMPLETE AND RETURN TO jmcramer@sbcglobal.net OR YOUR RESIDENCY PROGRAM ADMINISTRATIVE ASSISTANT WHO WILL FORWARD TO THE SCMS
Available online at www.SaginawCountyMS.com under the Membership tab

I, ____ ☐ MD ☐ DO ☐ DPM hereby apply for membership in the SAGINAW COUNTY MEDICAL SOCIETY, component of the MICHIGAN STATE MEDICAL SOCIETY. I agree to supports its Constitution and Bylaws, the MSMS Constitution and Bylaws, and the Principles of Ethics of the American Medical Association as applied by the AMA and the MSMS Judicial Commission.

Residency Program (check one) ☐ EM ☐ FM ☐ IM ☐ Ob/Gyn ☐ Peds ☐ Podiatry ☐ Psychiatry ☐ Surgery

Primary Email ____ *(required)*

Home Address _________________________________ City _______________, State _______ Zip ______________

Cell/Mobile (with area code) __________________ Secondary Email _________________________________

Maiden Name ________________________

Date of Birth _____________ Place of Birth ____

Sex ☐ Male ☐ Female Marital Status _________________ Spouse's Name _________________________________

Education

College/University ____ Year Graduated __________ Degree __________

Medical School ___________________________________State/Country________________ Year Graduated_________

Previous Residency/Fellowship

Previous Hospital _________________________ City_________________ Specialty ___________ From_____ to ______

Previous Hospital _________________________ City_________________ Specialty ___________ From_____ to ______

Anticipated Date of Completion?_________

If a graduate of a foreign medical school, please include your ECFMG #_____________________

Year licensed in Michigan _________________ Michigan License Number __________________

Have you completed a residency training program in another specialty? ☐ Yes ☐ No

If yes, what? ____

Have you ever been denied licensure? ☐ Yes ☐ No If yes, please explain: __________________________________

Have you ever been expelled from or had your contract revoked by a hospital or residency program? ☐ Yes ☐ No

If yes, please explain: ____

MILITARY SERVICE

Branch____ From ________ to ________

✍____ Date ____________________

Signature of Applicant

Sponsor *(Residency Program Director)* ____________________, ☐ MD ☐ DO ☐ DPM

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