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 ☐ Podiatry ☐ Psychiatry ☐ Surgery

Email _____ *(required)*

Home Address _____ City _____, MI Zip _____

Phone (with area code) _____ 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

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