Medical Society Membership Application

I, _____, ☐ MD ☐ DO hereby apply for membership in the SAGINAW COUNTY MEDICAL SOCIETY, component of the MICHIGAN STATE MEDICAL SOCIETY. I agree to support 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.

☐ Office Address _____ Zip _____

Phone (_____) _____ Fax (_____) _____ Email _____

Practice Name _____

☐ Home Address _____ Zip _____

Phone (_____) _____ Email _____

✓ Please check address to which you want SCMS/MSMS mail delivered.

Maiden Name _____

Date of Birth ____/____/_____ Place of Birth _____

Sex ☐ Male ☐ Female Marital Status _____ Spouse's Name _____

Hospital Affiliation 1_____ 2_____ 3_____

NPI Number _____

Education – *No need to rewrite if included on your CV which you will attach to this application*

College/University _____ Year Graduated _____ Degree _____

Medical School _____State/Country_____ Year Graduated_____

Internship

Hospital _____ City_____ Specialty _____ From_____ to _____

Residencies or Fellowships

Hospital _____ City_____ Specialty _____ From_____ to _____

Hospital _____ City_____ Specialty _____ From_____ to _____

Hospital _____ City_____ Specialty _____ From_____ to _____

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

Year licensed in Michigan _____ Michigan License Number _____

License held in other states 1_____ 2_____ 3 _____

Have you ever been dropped, expelled or suspended from any local, state or national medical society? ☐ Yes ☐ No

If yes, please attach separate sheet giving details

SPECIALTY Year Board Certified Board Eligible

Primary _____ _____ ☐ Yes ☐ No

Secondary _____ _____ ☐ Yes ☐ No

Location of previous practice

_____ From _____ to _____

_____ From _____ to _____

_____ From _____ to _____

MILITARY SERVICE

_____ From _____ to _____

Current medical and/or specialty society membership: _____

_____

Fellow, American College of _____ Date _____

↘_____ Date _____

Signature of Applicant

A CURRENT CV MUST BE SUBMITTED WITH APPLICATION

"I have contacted the following two SCMS members who have agreed to act as my sponsors and provide references if requested."

1._____

2._____

SCMS Use Only–Hospital Credentials

_____

_____

_____

_____

_____

_____

When completed, please mail with CV to:

Joan M. Cramer, Executive Director
Saginaw County Medical Society
350 St. Andrews Road, Suite 242
Saginaw, Michigan 48638-5988
Phone (989)-790-3590 Cell (989)-284-8884
NEW FAX 2/22 989-331-6720
Email jmcramer@sbcglobal.net
www.SaginawCountyMS.com

If available, please email your photo to jmcramer@sbcglobal.net for use in the Bulletin and Membership Directory. If not available, please include a photo with your application which will be scanned and used in the Bulletin and Directory.

For office use
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