Medical Society of Delaware

MAIN # (302) 366-1400
FAX (302) 366-1354
Membership@medsocdel.org

Physician Application for Membership

What prompted you to apply for membership/why would you like to join MSD?

If you were referred by a currently active MSD member please print the MSD member's name who encouraged you to join:

Your Name _____ ❑ **MD** ❑ **DO**
First Middle Last Maiden Name (if applicable)

Employer/Group _____
(Please indicate Parent Company Name. Note: May or may not be the same as DBA Practice Name below. Group memberships will be identified by this name.)

DBA Practice Name _____ **Office Phone** _____
("Doing Business As" Practice name may or may not differ from Employer/Group Name)

Primary Office Address _____ **Office Fax** _____
(**MSD must have office address on file if practicing**.)

Office Mailing Address (if different from above) _____

Additional office information (address/phone/fax) ❑ none 1. _____

2. _____ 3._____
Please include an attachment if more space is needed.

MSD provides practice information tailored for office staff use. Please provide the following information:

Practice Manager _____ **Email** _____ Phone_____

Office Manager _____ **Email** _____ **Phone**_____

Physician's Preferred Email Address _____ **Cell Phone** _____
(MSD will deliver important, timely information affecting your practice and the health care industry to this address)

Home Address _____

MSD sends correspondence to both home and office, dependent upon the appropriate location for receipt.
Routine communications will be sent to the preferred mailing address checked below:

Preferred Mailing Address: ❑ Home ❑ Office
Preferred Billing Address: ❑ Home ❑ Office (If address is different from above, please list below)

Billing Office Address: _____

How would you prefer to be contacted regarding membership renewal? ❑Mail ❑Email

MSD membership is annual – January 1 to December 31. Dues invoices are sent beginning after the Annual Meeting in November each year.

Date of Birth _____ **Gender** ❑ **Male** ❑ **Female** ❑ **Self-Describe** _____ ❑ **Prefer not to answer**

Ethnicity
❑ **Hispanic, Latinx or Spanish origin**
❑ **Not of Hispanic, Latinx or Spanish origin**

Race Please check all that apply:
❑ **Black or African American**
❑ **American Indian or Alaska Native**
❑ **Asian**
❑ **Native Hawaiian or Other Pacific Islander**
❑ **White**
❑ **Other** _____

Languages spoken fluently _____

Spouse/Significant Other's Full Name _____

U.S. Citizen? ❑ Yes ❑ No, please explain your status in the U.S._____ **International Medical Graduate? ❑ Yes ❑ No**

Education & Training	Hospital Name	Specialty	Began (mo/yr)	Ended (mo/yr)
Medical School				
Internship				
Residency				
Fellowship				
additional				

Primary Specialty _____ **Board Certification Expiration** _____
(***Primary is defined as the specialty for which you devote the majority of your daily practice and by which MSD will identify you.***)

Subspecialty or other Specialty _____ **Board Certification Expiration** _____

Special Medical Interests _____

Interest in speaking to the Media/what topics? _____

DE Medical License_____ **AMA Med Ed#**_____ **ECFMG Cert# (if applicable)** _____ **NPI** _____

Practice Status: ❑ Private Practice ❑ Employed *(defined as a practice which is not physician-owned)*

Practice Type: ❑ Administration ❑ Concierge Medicine ❑ Corporation/Business ❑ Direct Primary Care (DPC) payment model
❑ Government ❑ Group Subcontractor ❑ Individual Consultant ❑ Locum Tenens ❑ Private Practice – Group
❑ Private Practice – Solo ❑ Teaching/Academic ❑ Telemedicine ❑ Traveling

Practice Setting: ❑ Office ❑ Ambulatory Surgery Center ❑ Clinic (charitable) ❑ Federally Qualified Health Center
❑ Free Standing Emergency ❑ Government Office ❑ Home Office ❑ Hospital/Health System ❑ Medical Aid Unit
❑ University/Medical School ❑ Urgent Care

Current Medical & Specialty Society Memberships/Year joined _____

Current State Medial Society memberships/Year joined/Year lapsed _____
_____

Have you ever been the subject of an investigation (pending, current, or closed) by a medical licensing board, state agency or health care institution with regards to unprofessional conduct, clinical competency, or criminal behavior as defined in 24 Del. Code, §1731❑ Yes ❑ No (*If yes, please explain. Your application will be held pending the outcome of the investigation*.)
§1731 can be found on the State of Delaware website: http://delcode.delaware.gov/title24/c017/sc04/index.shtml

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Those deemed eligible for active membership will possess a doctor of medicine/osteopathic medicine degree or recognized international equivalent and an unrestricted license to practice medicine and surgery in the State of Delaware (as defined by the Delaware Board of Medical Licensure and Discipline). Membership eligibility is based on good moral character, professional standing, and professional ethics, as well as conduct as defined in 24 Del C., 1731(b) of the Medical Practice Act and as Title 24, Chapter 17 of the Medical Practice Act may be amended from time to time. If approved for membership, I agree to conduct myself professionally and personally according to the principles of medical ethics of the American Medical Association and to be governed by the Bylaws of the Medical Society of Delaware (MSD). By signing this application and upon approval of my membership in MSD, I understand I will receive communications (via various means) from MSD as a member of the organization. Membership dues are prorated based on approval date.

Applicant's Signature _____ Date _____
By signing above and submitting this form I attest that information contained within this document is true and accurate. I certify that I know, understand, and comply with all requirements for membership in MSD. Electronic signature acceptable; typed name acts as legal signature.

Actions of the Society (Internal Use only) Recruitment Code: _____ Membership Type: _____
Application Received: _____ Entered into Database: _____ Acknowledgement Sent: _____
Sent to COM: _____ COM Approval: _____ Listed in Newsletter: _____ ❑ Accepted ❑ Rejected
Membership Approval: _____ Join Date: _____ Welcome Packet/Letter Sent: _____
Database/New Member list updated: _____ Notes:

Updated 4/1/22