Medical Society of Delaware

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

Resident/Fellow Application for Membership

(MSD membership for those in training is FREE)

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

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

Home Address ____ **Cell Phone** ____________

Preferred Email Address ____
(Email is required to login to the MSD website and to receive communication sent via email.)

Hospital ________________________ **Residency/Fellowship Program**________________________

Residency Coordinator ____________________________ **RC's email** ____________________

Hospital Mailing Address ____
❑ Please mail correspondence to the hospital address above. *Unless otherwise indicated, mail will be sent to your home address on file.*

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**

Foreign Languages spoken fluently ________________

Spouse/Significant Other's Full Name ________________

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

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

Medical School ______________________________ Graduation Date: ________________

Education & Training	Hospital Name/Location	Specialty	Began (mo/yr)	Will End/Ended (mo/yr)
Internship				
Residency				
Fellowship				
Additional				

Special Medical Interests ________________ **Interest in speaking to the Media/what topics?** ________________

DE Medical License__________ **AMA Med Ed#**__________ **ECFMG Cert#** (if applicable) __________ **NPI** _______

Do you plan to stay in Delaware after graduation from Residency/Fellowship Training? ❑ Yes ❑ No ❑ Possibly/Unsure

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.

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 4/4/22