Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713 ▪ PHONE (302) 366-1400 ▪ FAX (302) 366-1354 ▪ EMAIL: Membership@medsocdel.org

APPLICATION FOR MEMBERSHIP – PHYSICIAN ASSISTANT

To be eligible for membership, applicants must be Delaware licensed physician assistants who are in good standing with their licensing board. The physician assistant must continue to meet these requirements and submit annual dues in a timely manner in order to remain a member of the Medical Society of Delaware.

Your Name ____
First Middle Last Maiden Name (If applicable) Credential(s)

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

DBA Practice Name ____
("Doing Business As" Practice Name may or may not differ from Employer/Group Name)

Office Address ____
(**MSD must have office address on file**.)

City ______________ **State** ______ **Zip** ________ **Office Fax** ______________

Email Address ____
(MSD will deliver important, timely information to the email address you list. Our general mode of communication is through email.)

Home Street Address ______________________ **Home Phone** ______________

City ______________ **State** ______ **Zip** ________ **Cell Phone** ______________

MSD does, from time to time, send correspondence to both home and office, dependent upon the appropriate location for receipt. However, communications that are mailed will normally be sent to the preferred address indicated below:

Preferred Mailing Address: ___ Home Address ___ Office Address

BIOGRAPHICAL DATA

DATE OF BIRTH ____ /____ /_______ **GENDER:** ___Male ___ Female **MARITAL STATUS:** ____ Single ____Married
MM DD YYYY

If married, spouse's full name ____
First M.I. Last

U.S. Citizen: ___Yes ___No **If no, please explain your status in the U.S.**: ______________

Languages Spoken (fluently, in addition to English) ______________________________

EDUCATION/TRAINING (If you have additional training information to provide, please attach your Curriculum Vitae)

Training	School Name & Location	Years Attended/ Graduation Year	Specialty Area	Certification Exam Date
Physician Assistant Accredited Program				
Additional Training				

Delaware Physician Assistant License Number ______________________ **Year Issued** ____________

TYPE OF PRACTICE/AFFILIATIONS (CHECK ALL THAT APPLY)

____ Physician Ofc. Private Practice Setting Indicate type: ___ Solo ___ Group (___) Number of Physicians in Group

____ Hospital System _____ Urgent Care Setting _____ Medical Aid Facility

____ Ambulatory Surgical Center ____ Clinic (FQHC/Free Standing/Charitable) ____ Free Standing Emergency Facility

____ Government Agency (State/Federal) ____ Corporate/Business ____ Traveling

____ Other (specify): ____

Within the last five (5) years, have you been convicted of a felony crime? ______ Yes _____ No
(If "YES," please provide details below and include dates.)

Within the last five (5) years, has your license to practice in any jurisdiction been limited, suspended, or revoked?
(If "YES," please provide details and include dates.) _______ Yes ______ No

Within the last five (5) years, have you been the subject of disciplinary action by any professional medical association, hospital/medical staff, or licensing board? _______ Yes ______ No
(If "YES," please provide details include dates.)

Are you the subject of any current or pending investigation with regards to clinical competency or ethical conduct as defined in 24 Del. Code, §1731? _____ Yes _____ No *(If yes, please include your explanation with this application. 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

Please provide names and contact information for two references. One reference must be a physician, preferably a physician who can speak to your professionalism.

NAME AND CREDENTIALS	PHONE	EMAIL (REQUIRED)

Those deemed eligible for Affiliate Membership will possess a recognized degree from an accredited program, passed an acceptable certifying examination and remain current, and be licensed in Delaware as a Physician Assistant (as defined by the Delaware Board of Medical Licensure and Discipline). Membership eligibility is based on good moral character, professional standing, professional ethics, and professional 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. Membership is contingent upon complete submission of requested application information, application approval, and payment of any required membership dues.

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 abide by and comply with the Bylaws of the Medical Society of Delaware. By signing this application and upon approval of my membership in MSD and payment of any required dues, I understand I will receive communications (via various means) from MSD as a member of the organization.

Applicant's Signature ____ Date ____/____/____
By signing above I certify that I know, understand, and comply with all requirements for membership in MSD. (A typed name or electronic signature for the signature line will be accepted for online application submission.)

(For Office Use Only) **Recruitment Code:** WEB **Membership Classification** PA ☐ Accepted ☐ Declined

Application Received: ___/___/_____ Entered into database: ___/___/_____ App Acknowledgement: ___/___/_____

Survey to References: ___/___/_____ Survey Rec'd Ref #1: ___/___/_____ Survey Rec'd Ref #2: ___/___/_____

To Committee: ___/___/_____ To Membership: ___/___/_____ Join Date: ___/___/_____

Committee approval date: ___/___/_____ Membership Approval: ___/___/_____ Welcome Letter: ___/___/_____

Notes: ____