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 ______________________________ **Office Fax** ________________

(**MSD must have office address on file**.)

Office Mailing Address (if different from above) ______________________________

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 ______________________________ **Cell Phone** ________________

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 different from above, please list below)

Billing Office Address: ____

BIOGRAPHICAL DATA

DATE OF BIRTH _____/_____/________ GENDER: ❑ Male ❑ Female ❑ Self-Describe __________ ❑ Prefer Not to Answer

MM DD YYYY

Spouse/Significant other's full name ____

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): ____

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 below or on additional paper. 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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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)**

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

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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: ____

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