



Medical Society of Delaware

900 PRIDES CROSSING, NEWARK, DE 19713 • PHONE (302) 366-1400 • FAX (302) 366-1354 • EMAIL: MEMBERSHIP@MEDSODEL.ORG

APPLICATION FOR MEMBERSHIP

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

If referred by an active MSD member and to ensure proper credit for the Member Recruitment Incentive Program, please print the MSD member physician's name who encouraged you to join:

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

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 this name.)

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

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

Office Mailing Address (If different from location above) _____

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

Home 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 is different from above, please list below)

Billing Office Address: _____

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

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

Practice Manager _____ Email _____ Phone _____

Office Manager _____ Email _____ Phone _____

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) _____ International Medical Graduate? Yes No

EDUCATION/TRAINING

Medical School _____ Graduation Year _____

Training	Hospital Name	Specialty	Began (mo/yr)	Ended (mo/yr)
Internship				
Residency				
Fellowship				

(Continued on other side)

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 **If Private Practice (check only one):** Solo Group ____ (# physicians)

Employed (defined as a practice which is not physician-owned)

PRACTICE TYPE

Administration Concierge Medicine Corporate/Business Direct Primary Care Government

Group Subcontractor Consultant Locum Tenens Research Teaching/Academic Telemedicine Traveling

PRACTICE SETTING

Ambulatory Surgical Center Clinic (FQHC/Free Standing/Charitable) Free Standing Emergency Home Office

Hospital or Hospital System Medical Aid Unit Office Based University/Medical School Urgent Care

Current Medical & Specialty Society Memberships/Year joined _____

Previous State Medical 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>

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.

For office use only **Recruitment Code:** WEB **Membership Type:** _____ Accepted Declined

Application Received: ____/____/____ Entered in Database: ____/____/____ App Acknowledgement: ____/____/____

Payment Amount Required: \$ _____ Payment Received: ____/____/____

To Committee ____/____/____ To Membership ____/____/____ Join Date ____/____/____
Approval ____/____/____ Approval ____/____/____ Welcome Letter ____/____/____

Notes: _____
Rev. 7/27/2021