



Medical Society of Delaware Physician Membership Application

Email to Membership@medsocdel.org or fax to (302) 366-1354

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 _____

(Required) The email is your MSD website login and it is also used for member communication. Some communications are sent via Constant Contact. Please do not unsubscribe from your communications. If you wish not to receive the weekly eNews and Views, simply advise us and we will remove you from the mailing list.

Home Address _____

MSD sends correspondence to both home and office, dependent upon the appropriate location for receipt.

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

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.

If you use social media, which do you use to obtain current news? _____

How do you prefer to obtain current healthcare news? _____

How do you prefer MSD communicates with you? Please check all that apply.

Phone USPS Mail Email Text Social Media URL(s) _____

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

Gender Identity Man Woman 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				

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

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? _____

Are you interested in participating in MSD's Mentor Program? Yes No (if yes, MSD staff will follow up with you regarding the program)

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>

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 Internal Use Only – Actions of the Society	Recruitment Code: _____	Membership Type: _____	Date Application Received: _____
Entered into Database: _____	Acknowledgement Sent: _____	Sent to COM: _____	COM Approval: _____
<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected		Membership Approval/Join/Welcome Letter : _____	Notes: _____