Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

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

Medical Student Membership Application

Name: _____
First Middle Last

Home Address: _____ City, State, Zip _____

Cell Phone #: _____ Email Address: _____
(*Required to receive login for members-only content of MSD website and for any emailed communications.*)

Preferred mailing for any MSD print communications **(choose one):** ☐ School ☐ Home ☐ Hospital

Gender: ☐ Male ☐ Female ☐ Self-Describe _____ ☐ Prefer not to answer

Date of Birth _____/_____/_____ Foreign Languages spoken fluently: _____
MM DD YYYY

U.S. Citizen ☐ YES ☐ NO If no, please explain your status in the U.S. _____

Special Medical Interests: _____

Medical Training	Name/Full Address	Degree upon completion of medical school (ex. MD, DO)	Began (mo/day/yr)	Anticipated Graduation Date (mo/day/yr)	Medical School accredited by the Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA)? Y/N
Medical School					

Are you a Branch Campus Student: ☐ Yes ☐ No IF YES, LOCATION (HOSPITAL): _____

Are you a DIMER Student: ☐ Yes ☐ No Residency plans (if known): _____

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

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

_____

Membership eligibility is based on good moral character, professional standing, and professional ethics, as well as appropriate professional conduct 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. 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. By signing this application and upon approval of membership in MSD, I understand I will receive communications (via various means) from MSD as a member of the organization.
(http://delcode.delaware.gov/title24/c017/sc04/index.shtml).

Upon completion of Medical School, I will contact the Medical Society of Delaware to confirm continuation of membership during Residency training and provide updated information regarding contact and Residency training program information.

Your Signature _____ **Date** ____/__/____

By signing above I certify that I know, understand, and comply with all requirements for membership in MSD. Typed name acts as legal signature.

ACTIONS OF THE SOCIETY (Internal Use Only) Recruitment Code Membership Type MS

Application Received ____/____/____ Entered in System ____/____/____ App Acknowledgement ____/____/____

Committee Approval ____/____/____ Membership Approval _____/_____/_____ □ Accepted □ Rejected

NOTES: _____

Rev.7/2021 Join Date ____/____/____ Welcome Letter Sent ____/____/____