



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

Membership Type: Active Affiliate Associate

To ensure proper credit through the Member Recruitment Incentive Program, please print the MSD member physician's name who encouraged you to join:

Your Name _____ M.D. _____ D.O. _____
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)

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

City _____ State _____ Zip _____

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

Home Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell _____

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

Preferred Mailing Address: ___ Home Address ___ Office Address

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

Practice Manager _____ Email _____ Phone _____

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

Medical School _____ Graduation Year _____

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

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

(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)

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

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 Hospital Affiliations/Year Affiliated _____

Current Teaching Affiliations/Year Affiliated _____

Current Medical & Specialty Society Memberships/Year joined _____

Previous State Medical Society Memberships/Year joined/Year lapsed _____

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 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 I certify that I know, understand, and comply with all requirements for membership in MSD.

For office use only Recruitment Code: _____ Membership Type: _____ Accepted Declined
Application Received: ____/____/____ Entered in Database: ____/____/____ App Acknowledgement: ____/____/____
Payment Received: ____/____/____
To Committee ____/____/____ To Membership ____/____/____ Join Date ____/____/____
Approval ____/____/____ Approval ____/____/____ Welcome Letter ____/____/____
Notes: _____
Rev. 07/19