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

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

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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 ____

City ______________________________ State ________ Zip ________ Cell ______________________

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: ____

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

Practice Manager ______________________ Email ______________________ Phone ______________

BIOGRAPHICAL DATA

DATE OF BIRTH ___ / ___ / _____
MM DD YYYY

GENDER __Male __Female International Medical Graduate? ☐ Yes ☐ No

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	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) __________

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

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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:**________ **Membership Type:**________ ☐ Accepted ☐ Declined

Application Received: ___/___/_____ Entered in Database: ___/___/_____ App Acknowledgement: ___/___/_____

Payment Amount Required: $__________ Payment Received: ___/___/_____

To Committee Approval _____/_____/_________ To Membership Approval _____/_____/_________ Join Date ____/____/________

Welcome Letter _____/_____/_________

Notes:____________________

Rev. 10/8/2020