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, ST, Zip ______________

Cell Phone #: ______________ Email Address ______________________________
(Required to receive login for members-only content of MSD website and for any e-mailed communications.)

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

GENDER: ☐ Male ☐ Female Special Interests: ______________________________

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. ______________________

EDUCATION/TRAINING

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					

Residency plans (if known): ____

____

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

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 AF-MS

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

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

NOTES: ____

1/2018 Join Date ____/____/____ Welcome Letter Sent ____/____/____