Medical Society of Delaware

900 Prides Crossing, Newark, DE 19713

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

RESIDENT/FELLOW Membership Application

(MSD membership for those in training is FREE)

Name: ______________________________ MD ____ DO ____
First Middle Last Maiden (if applicable)

Home Address: ______________________________ City, St, Zip ______________

Cell #: ______________ Preferred Email Address ______________

(*Email required* ***to login to MSD website and for receipt of communications sent via email.***)

Hospital: ______________________________

Street Address: ______________________________

City, ST, Zip: ______________________ ___ Please mail correspondence to hospital address above.

Unless otherwise indicated, mail will be sent to your home address on file.

GENDER:___ Male ___Female ___Other Date of Birth ___ / ___ / ___ Foreign Languages Spoken ______________

U.S. Citizen:___YES___NO If no, please explain your status in the US: ______________

Married? ___ YES ___ NO If yes, spouse name: ______________

Residency Coordinator: ______________ Email ______________ Phone ______________

EDUCATION/TRAINING

Medical School ______________________________ Graduation Date ______________

Medical Training	Hospital Name/City, State	Specialty	Began (mo/yr)	Expected Completion Date (mo/yr)
Internship				
Residency				
Fellowship				

DE Medical License#______________ ECFMG Cert.# ______________ NPI# ______________

(DE Medical License must be ACTIVE to qualify for MSD membership.) *(If Applicable)*

Do you plan to stay in Delaware after graduation from Residency/Fellowship Training? ___Yes ___No ___Unsure

Those deemed eligible for membership will possess an MD/DO degree or AMA-recognized 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 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)

Your Signature______________________________ Date ______________

By signing above I certify that I know, understand, and comply with all requirements for membership in MSD. Typed signature accepted for online application completion.

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

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

Committee Approval ___/___/___ Membership Approval ___/___/___ □ Accepted □ Rejected

NOTES: ______________________________

Rev 6/3/2020 Join Date ___/___/___ Welcome Letter Sent ___/___/___