Medical Society of Delaware
Medical Student Application

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

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

Your Name _____
First Middle Last Maiden Name (if applicable)

Home Address _____ **Cell Phone** _____

Preferred Email Address _____
(Required) The email provided will be your MSD website login and it is also used for member communication.

If you use social media, which do you use to obtain current news? _____

How do you prefer to obtain current healthcare news? _____

How do you prefer MSD communicates with you? (check all that apply)
❑ Phone ❑ USPS Mail ❑ Email ❑ Text ❑ Social Media URL(s) _____

Date of Birth _____ **Gender** ❑ **Male** ❑ **Female** ❑ **Self-Describe** _____ ❑ **Prefer not to answer**

Ethnicity ❑ **Hispanic, Latinx or Spanish origin**
❑ **Not of Hispanic, Latinx or Spanish origin**

Race Please check all that apply:
❑ **Black or African American**
❑ **American Indian or Alaska Native**
❑ **Asian**
❑ **Native Hawaiian or Other Pacific Islander**
❑ **White**
❑ **Other** _____

Foreign Languages spoken fluently: _____
_____

U.S. Citizen? ❑ **Yes**
❑ **No, please explain your status in the U.S.**_____

International Medical Graduate? ❑ **Yes** ❑ **No** **Undergraduate School:** _____

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				

Special Medical Interests _____

Interest in speaking on medical topics? (if so, what topics?) _____

Branch Campus Student? ❑ Yes, location (hospital): _____ ❑ No

Are you from Delaware? ❑ Yes ❑ No **Apollo Youth in Medicine participant?** ❑ Yes ❑ No **DIMER student?** ❑ Yes ❑ No

Residency Plans (if known) _____

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.

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.