Medical Society of Delaware
Resident/Fellow Membership Application

Email to Membership@medsocdel.org or fax to (302) 366-1354

Your Name _____ ❑ **MD** ❑ **DO**
First Middle Last Maiden Name (if applicable)

Home Address _____

Preferred Mailing Address: ❑ Home ❑ Hospital **Cell Phone** _____

DE Medical License # _____ **AMA Med Ed#:**_____

ECFMG Cert# (if applicable) _____ **NPI # :** _____

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

Date of Birth _____

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

Gender Identity ❑ **Man** ❑ **Woman** ❑ **Self-Describe** _____ ❑ **Prefer not to answer**

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

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

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

Foreign Languages spoken fluently: _____

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

Medical School (Name and Location) _____

Graduation Date _____

During medical school, were you a branch campus student?
❑ Yes, location (hospital): _____ ❑ No

Education & Training	**Hospital Name/Location**	**Specialty**	**Began (mo/yr)**	**Will End/ Ended (mo/yr)**
Internship				
Residency 1				
Residency 2				
Fellowship 1				
Fellowship 2				
Other				

Special Medical Interests _____

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

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

DIMER student? ❑ Yes ❑ No

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) _____

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

_____

How did you hear about MSD?

_____

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.

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.

Actions of the Society (Internal Use only) Recruitment Code: _____ Membership Type: Resident/Fellow

Application Received: _____ Entered into Database: _____

Acknowledgement Sent: _____ Sent to COM: _____ COM Approval: _____

Listed in Newsletter: _____ ❑ Accepted ❑ Rejected Membership Approval: _____

Join Date: _____ Welcome Packet/Letter Sent: _____

Notes:

revised 8.24.23