Medical Society of Delaware
Physician Assistant Application

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

To be eligible for membership, applicants must be Delaware licensed physician assistants who are in good standing with their licensing board. The physician assistant must continue to meet these requirements and submit annual dues in a timely manner in order to remain a member of the Medical Society of Delaware.

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

Employer/Group _____
(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 _____ **Office Phone** _____
("Doing Business As" Practice name may or may not differ from Employer/Group Name)

Primary Office Address _____ **Office Fax** _____
(MSD must have office address on file if practicing.)

Office Mailing Address (if different from above) _____

Additional office information (address/phone/fax) ❑ none 1. _____

2. _____ 3._____
Please include an attachment if more space is needed.

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

Practice Manager _____ **Email** _____ Phone_____

Office Manager _____ **Email** _____ **Phone**_____

Preferred Email Address _____ **Cell Phone** _____
(Required) The email is your MSD website login and it is also used for member communication. Some communications are sent via Constant Contact. Please do not unsubscribe from your communications. If you wish not to receive the weekly eNews and Views, simply respond and we will remove you from the mailing list.

Home Address _____

MSD sends correspondence to both home and office, dependent upon the appropriate location for receipt.

Preferred Mailing Address: ☐Home ☐Office **Preferred Billing Address:** ❑ Home ❑ Office (If address is different from above, please list here _____

How would you prefer to be contacted regarding membership renewal? ❑Mail ❑Email

MSD membership is annual – January 1 to December 31. Dues invoices are sent beginning after the Annual Meeting in November each year.

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? Please 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**

Languages spoken fluently _____

Spouse/Significant Other's Full Name _____

Training	School Name & Location	Years Attended/ Graduation Year	Specialty Area	Certification Exam Date
Physician Assistant Accredited Program				
Additional Training				

(If you have additional training information to provide, please attach your Curriculum Vitae)

DE Physician Assistant License # _____ **Year Issued** _____ **NPI** _____

Practice Status: ❑ Private Practice ❑ Employed *(defined as a practice which is not physician-owned)*

Practice Type: ❑ Administration ❑ Concierge Medicine ❑ Corporation/Business ❑ Direct Primary Care (DPC) payment model ❑ Government ❑ Group Subcontractor ❑ Individual Consultant ❑ Locum Tenens ❑ Private Practice – Group ❑ Private Practice – Solo ❑ Teaching/Academic ❑ Telemedicine ❑ Traveling

Practice Setting: ❑ Office ❑ Ambulatory Surgery Center ❑ Clinic (charitable) ❑ Federally Qualified Health Center ❑ Free Standing Emergency ❑ Government Office ❑ Home Office ❑ Hospital/Health System ❑ Medical Aid Unit ❑ University/Medical School ❑ Urgent Care

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 below or on additional paper. 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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_____

Please provide names and contact information for two references. One reference must be a physician, preferably a physician who can speak to your professionalism.		
NAME AND CREDENTIALS	**PHONE**	**EMAIL (REQUIRED)**

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

_____

Those deemed eligible for Affiliate Membership will possess a recognized degree from an accredited program, passed an acceptable certifying examination and remain current, and be licensed in Delaware as a Physician Assistant (as defined by the Delaware Board of Medical Licensure and Discipline). Membership eligibility is based on good moral character, professional standing, professional ethics, and professional 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. Membership is contingent upon complete submission of requested application information, application approval, and payment of any required membership dues.

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 abide by and comply with the Bylaws of the Medical Society of Delaware. By signing this application and upon approval of my membership in MSD and payment of any required dues, 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.

For Internal Use Only – Actions of the Society **Recruitment Code:**_____ **Membership Type:** _____ **Date Application Received:** _____

Entered into Database: _____ **Acknowledgement Sent:** _____ **Sent to COM:** _____ **COM Approval:** _____ **Newsletter:** _____

❑**Accepted** ❑ **Rejected** **Membership Approval/Join/Welcome Letter :** _____ **Notes:**