



MICHIGAN STATE  
 MEDICAL SOCIETY  
 120 W. Saginaw, Lansing, MI 48823  
 msms@msms.org • www.msms.org  
 517-336-5762

**State and County Medical Society**  
**Membership Application**

CALHOUN COUNTY  
 MEDICAL SOCIETY  
 PO Box 278  
 Battle Creek, MI 49016-0278  
 269-660-0893 • Calhouncms@yahoo.com

Do you work 20 hours or less per week?  YES  NO  
 Is your spouse a member of MSMS?  YES  NO  
 Is this the first year you have practiced in Michigan?  YES  NO

Please PRINT or TYPE

FULL NAME \_\_\_\_\_ MD or DO (Circle One)  
Last First Middle Initial  
 HOME ADDRESS, CITY & ZIP \_\_\_\_\_  
Area Code & Telephone Number  
 OFFICE ADDRESS, CITY & ZIP \_\_\_\_\_  
Area Code & Telephone Number  
 PRACTICE NAME \_\_\_\_\_  
Office Fax Number  
 EMAIL ADDRESS \_\_\_\_\_ For mailing, please use (check one):  Office address  Home address

**BIOGRAPHICAL DATA** Sex:  Male  Female Birth Place \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month Day Year  
 Maiden Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Government Service (check one):  Military  National Health Service Beginning Date \_\_\_\_\_ Completion Date \_\_\_\_\_

**EDUCATION (please complete or attach CV)**

INSTITUTION	LOCATION	DEGREE	YEAR GRADUATED	
			Beginning	Ending
College/University _____	_____	_____	_____	_____
Medical School _____	_____	_____	_____	_____

INTERNSHIP, RESIDENCY, AND FELLOWSHIPS	SPECIALTY	COMPLETION DATE
_____	_____	_____
_____	_____	_____

License: MI # \_\_\_\_\_ Date Issued \_\_\_\_\_ ECFMG # \_\_\_\_\_  
 License held in other states/countries (list states or countries) \_\_\_\_\_

**PROFESSIONAL DATA** Present Type of Practice (check appropriately):

OFFICE BASED:  Solo  Hospital Based  Teaching  Research  Government  
 Group Practice Name \_\_\_\_\_  Other (specify) \_\_\_\_\_

Specialty \_\_\_\_\_ Subspecialty \_\_\_\_\_

Board Certifications (list specialties & dates) \_\_\_\_\_

Present Hospital Appointments (list dates) \_\_\_\_\_

Teaching Appointments (list dates) \_\_\_\_\_

Previous Medical Society Membership (list dates) \_\_\_\_\_

Specialty Society Memberships \_\_\_\_\_

Within the last five years, have you been convicted of a felony crime?..... Yes  No If YES, please provide full information.  
 Within the last five years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?..... Yes  No If YES, please provide full information.  
 Within the last five years, have you been the subject of any disciplinary action by any medical society or hospital staff?..... Yes  No If YES, please provide full information.

I agree to support the CALHOUN COUNTY MEDICAL SOCIETY Constitution and Bylaws, the MICHIGAN STATE MEDICAL SOCIETY Constitution and Bylaws, and the Principles of Ethics of the American Medical Association as applied by the AMA and the MSMS Judicial Commission.

Signature \_\_\_\_\_ Date \_\_\_\_\_

WHEN COMPLETED, please mail to MSMS or Calhoun County Medical Society, or FAX to 517-336-5797. THANK YOU!

