APPLICATION FOR MEMBERSHIP

MEDICAL SOCIETY OF SEDGWICK COUNTY

DATE: _____

NAME: _____
First Middle Last MD/DO

PRACTICE NAME: _____

OFFICE ADDRESS: _____
Street Address City State Zip

OFFICE PHONE: _____ OFFICE FAX: _____

HOME ADDRESS: _____
Street Address City State Zip

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____ SPOUSE: _____

FOR SOCIETY MAILINGS PLEASE USE MY: ☐ OFFICE ADDRESS ☐ HOME ADDRESS ☐ EMAIL ADDRESS

A CURRENT COLOR PHOTO MUST ACCOMPANY THIS APPLICATION. Please do not send a photo copy of a picture or a picture printed on copy paper. You may email a jpg image to rhondawelch@med-soc.org if it is more convenient. This picture will be used on the public page of MSSC's online Physician Finder and in the MSSC annual pictorial membership roster.

MEDICAL SCHOOL:

Institution: _____ MD or DO

_____
City State

Dates:_____ (Mo/Yr)

INTERNSHIP: Institution:_____

_____
City State

Dates: _____ (Mo/Yr)

RESIDENCY:

Specialty: _____

Institution:_____

_____
City State

Dates: _____ (Mo/Yr)

FELLOWSHIP(s):

Specialty: _____

Institution:_____

_____
City State

Dates: _____ (Mo/Yr)

Specialty: _____

Institution_____

_____
City State

Dates: _____ (Mo/Yr)

NOTE: This application will be considered by the Board of Directors of the MSSC. Questions should be referred to the Executive Director, Medical Society of Sedgwick County, 1102 S. Hillside, Wichita, KS 67211, 316-683-7557. You may also contact Rhonda Welch, Membership Coordinator, at 316-683-7670.

FELLOWSHIP(s) Continued:

Specialty: _____

Institution:_____

_____
City State

Dates: _____ (Mo/Yr)

Licenses held in other states:_____

Wichita hospital staff affiliations: _____

Practice specialty: _____

Do you limit your practice to this specialty? ☐ Yes ☐ No

Board certification(s): (name & date certified)_____

_____

_____

Previous county medical society memberships: (list names)_____

_____

Previous state and national medical association memberships: (list names)

_____

Have you ever been under disciplinary action by any of these societies? ☐ Yes ☐ No

Are you proficient in languages other than English? If yes, please list. _____

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

DEA #:_____ SSN #: _____

Have you served in the U.S. Military? If so, please enclose a copy of your discharge papers. ☐ Yes ☐ No

Have you ever had an application for medical licensure, hospital privileges or prescribing privileges denied? ☐ Yes ☐ No

Have your medical license(s), your hospital privileges or prescribing privileges ever been limited, restricted, suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No

Have you had any professional liability claims filed against you? ☐ Yes ☐ No

Have you ever been convicted of fraud or felony? ☐ Yes ☐ No

If you answered yes to any of the past 4 questions, please include an explanation on a separate sheet and attach to this application.

PLEASE SEND A CURRENT CV AND COLOR PHOTO ALONG WITH THIS APPLICATION. Thank you!

I hereby apply for membership in the Medical Society of Sedgwick County.

I agree that the society may make such evaluation of my professional qualifications to be a member, as it deems necessary. I will furnish to the society all information requested of me for such purpose. If I have completed, signed and submitted a Medical Professional Application to Medical Provider Resources, I authorize release of a photocopy of that application and supporting documentation to the society to be utilized in evaluating my application for membership. I agree the society may use this release to request information regarding my hospital privileges.

I hereby release and hold harmless, from any liability or loss, the Medical Society of Sedgwick County, its members, agents and employees for acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications concerning my professional competence, ethical conduct, character and other qualifications for membership. This release shall not expire.

_____ _____

Applicant's signature Date

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