Skagit-Island

COUNTIES MEDICAL SOCIETY

FAX: 360.707.2008

APPLICATION FOR MEMBERSHIP

FULL NAME ______________________ M.D./D.O.

OFFICE ADDRESS: ______________________

____

CLINIC NAME: ______________________

PHONE: (360) ________ FAX: (360) ________

E-MAIL ADDRESS: ________

HOSPITAL AFFILIATION: ________ STATUS: ❑ ACTIVE ❑ PENDING ❑ SUSPENDED

(FOR MEMBER DIRECTORY)

HOME ADDRESS: ______________________

____

SPOUSE: ________ LEGISLATIVE DISTRICT: ❑ 10TH ❑ 40TH

PHONE: (360) ________ FAX OR EMAIL: ________

PREFER MAIL DELIVERED TO: ❑ HOME ❑ OFFICE

DATE OF BIRTH: ____/____/____ PLACE OF BIRTH: ________

SOCIAL SECURITY NUMBER: ________

MEDICAL SCHOOL ________ YEAR GRADUATED: ________

INTERNSHIP ________ YEAR GRADUATED: ________

RESIDENCY ________ YEARS ATTENDED: ________

POSTGRADUATE ________ YEARS ATTENDED: ________

SPECIALTY(IES): ______________________

BOARD CERTIFIED IN: ________ YEAR: ________

WASHINGTON LICENSE NUMBER: ________ YEAR ISSUED: ________

(CONTINUED ON BACK)

PREVIOUS PRACTICES AND MEDICAL SOCIETY AFFILIATIONS:

LOCATION	DATE

CURRENT MEDICAL SOCIETY MEMBERSHIP

____

DO YOU WISH TO TRANSFER MEMBERSHIP? ❑ YES ❑ NO

SIGNATURE OF TWO LOCAL COUNTY SOCIETY SPONSORS (**REQUIRED**)

	PRINTED NAME:
	PRINTED NAME:

DATE OF START OF PRACTICE IN SKAGIT, ISLAND OR SAN JUAN COUNTY: ____________

APPLICANT'S SIGNATURE	DATE

A COPY OF YOUR CURRENT WASHINGTON STATE MEDICAL LICENSE
MUST ACCOMPANY THIS APPLICATION.

RETIRED PHYSICIANS WHO ARE REQUESTING MEMBERSHIP MUST CALL
THE NATIONAL PRACTITIONER DATA BANK (800) 767-6732
TO REQUEST THAT A SELF QUERY BE MAILED TO THE ADDRESS BELOW.

RETURN COMPLETED FORM TO:

CHERYL THOMAS OR LINDA JONASSON, EXECUTIVE SECRETARIES
SKAGIT-ISLAND COUNTIES MEDICAL SOCIETY
PO BOX 646
BURLINGTON, WA 98233-0646