APPLICATION FOR MEMBERSHIP
The Philadelphia County Medical Society
Pennsylvania Medical Society

T

FULL NAME (*Print*) _____
Last First Middle

OFFICE_____
Street City, State Zip Area Code & Phone

FAX_____ E-MAIL _____

HOME_____
Street City, State Zip Area Code & Phone

FAX_____ E-MAIL _____

For Mailing, please use _____Office Address _____Home Address Spouse/Partner Name_____

SEX _____M _____F Date of Birth_____

EDUCATION	INSTITUTION	LOCATION	DEGREE	YR. GRADUATED
Medical	_____	_____	_____	_____
Residency	_____	_____	Year of Completion	_____
Fellowships	_____	_____	Year of Completion	_____

PROFESSIONAL DATA

License Pa. No._____ Date _____ Specialty _____

PRESENT TYPE OF PRACTICE (Check Appropriately)

☐ Office Based ☐ Solo ☐ Teaching ☐ Research

☐ Hospital Based ☐ Group –Name_____

☐ Other (Specify)_____

Present Hospital Appointments (List Dates)_____

Previous Medical Memberships (List Dates)_____

If you answer yes to any of the following questions, please attach full information.

☐ Yes ☐ No Within the last 5 years, have you been convicted of a felony crime?
☐ Yes ☐ No Within the last 5 years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?
☐ Yes ☐ No Within the last 5 years, have you been the subject of any disciplinary action by any medical society or hospital staff?

If elected to 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 Constitution and Bylaws of the Philadelphia County Medical Society, the Pennsylvania Medical Society and the American Medical Association.

By making application for membership in the Philadelphia County Medical Society, I hereby authorize the Society, in connection with its consideration of my application, to make inquiry of any of my references and institutions by whom I have been employed or extended privileges, as to my qualifications. I further authorize any of the above persons or institutions to forward any and all information their records may contain, and agree to hold them harmless from any action by me for their acts.

I hereby release, and hold harmless from any liability or loss, the Philadelphia County Medical Society, the Pennsylvania Medical Society and the American Medical Association, their officers, agents, employees and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I certify that the above statements are true. If any are found to be false, my membership may be terminated at the discretion of the Society.

DATE _____ APPLICANT'S SIGNATURE_____

Referred by: _____ Office Use: _____

CURRENT C.V. MAY BE ATTACHED TO PROVIDE ADDITIONAL INFORMATION

Please return this application to: The Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia, PA 19130