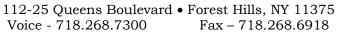


APPLICATION FOR MEMBERSHIP

MEDICAL SOCIETY OF THE COUNTY OF QUEENS &

MEDICAL SOCIETY OF THE STATE OF NEW YORK





Name	irst	M		Suffix		_
Home Address	Irst					
Home Tel ()		City Home Fax ()	State			_
E-Mail		Date of Birth		Male 🗖	Female	
Send Mail To: HOME ☐ OFFICE ☐	ı	Name of Spouse				_
Practice Name (If Applicable)		Manager's Email				
Office AddressStreet						_
Office Tel ()		City Office Fax ()	State		Zip	_
ARE YOU ACCEPTING NEW PATIENTS? Y	es 🗆 No 🗖					
Medical School		Year of Graduation _		MD □	DO	
Date Of Completion of Residency/Fellowship _		Other Degr	ees			_
Full Time ☐ Working Fewer Than 20 Hou	ırs/Week □					
CURRENT HOSPITAL AFFILI	IATIONS (If none, list a	any HMO affiliations). Ple	ease attach co	py of curr	ent CV.	
	IATIONS (If none, list a	any HMO affiliations). Ple		opy of curr	rent CV.	
CURRENT HOSPITAL AFFILI HOSPITAL/LOCATION		POSITION/SPECIAL	TY			
CURRENT HOSPITAL AFFILI HOSPITAL/LOCATION NYS LICENSE # D	ATE GRANTED	POSITION/SPECIAL	TY ENTERED PR	RACTICE		
CURRENT HOSPITAL AFFILI HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y	ATE GRANTED	POSITION/SPECIAL DATE I	TY ENTERED PR	RACTICE		
CURRENT HOSPITAL AFFILI HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y WORKERS' COMP BOARD RATING Has your license to practice medicine ever bee	ATE GRANTED EAR ECFMG # (If	POSITION/SPECIAL DATE I SPECIALTY attended medical schoo revoked, or voluntarily si	TY ENTERED PR I abroad)	RACTICE		
CURRENT HOSPITAL AFFILI HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y WORKERS' COMP BOARD RATING Has your license to practice medicine ever bee Have your privileges or employment at any hear revoked or voluntarily surrendered?	EAR ECFMG # (If an denied, suspended, alth care facility or entited)	POSITION/SPECIAL DATE I SPECIALTY attended medical school revoked, or voluntarily subjected to the second denied, suspective of the second denied in the second denied denied in the second denied in the second denied	ENTERED PR I abroad) urrendered? pended, termin	RACTICE	Yes 🗆	No 🗆
CURRENT HOSPITAL AFFILITION HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y WORKERS' COMP BOARD RATING Has your license to practice medicine ever bee Have your privileges or employment at any hear revoked or voluntarily surrendered? Have you ever been convicted of or pled guilty (If answering YES to any other properties).	EAR ECFMG # (If an denied, suspended, alth care facility or entity of the above three (3) or the above three	POSITION/SPECIAL DATE I SPECIALTY attended medical schoo revoked, or voluntarily su ty ever been denied, susp utes a misdemeanor or fe	ENTERED PR I abroad) urrendered? pended, terminelony?	RACTICE nated,	Yes □ Yes □ Yes □	No 🗆 No 🗅
CURRENT HOSPITAL AFFILI HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y WORKERS' COMP BOARD RATING Has your license to practice medicine ever bee Have your privileges or employment at any hear revoked or voluntarily surrendered? Have you ever been convicted of or pled guilty	EAR ECFMG # (If an denied, suspended, alth care facility or entity of the above three (3) or the above three	POSITION/SPECIAL DATE I SPECIALTY attended medical schoo revoked, or voluntarily su ty ever been denied, susp utes a misdemeanor or fe	ENTERED PR I abroad) urrendered? pended, terminelony?	RACTICE nated,	Yes 🗆	No 🗆 No 🗅
CURRENT HOSPITAL AFFILITION HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y WORKERS' COMP BOARD RATING Has your license to practice medicine ever bee Have your privileges or employment at any hear revoked or voluntarily surrendered? Have you ever been convicted of or pled guilty (If answering YES to any Have you ever been a member of this or any or	EARECFMG # (If en denied, suspended, alth care facility or entit to any act that constituty of the above three (3) quither county medical so	DATE I SPECIALTY attended medical schoo revoked, or voluntarily st ty ever been denied, susp utes a misdemeanor or fe uestions, please attach a na	ENTERED PR I abroad) urrendered? pended, terminelony?	RACTICE nated,	Yes □ Yes □ Yes □	No 🗆 No 🗅
CURRENT HOSPITAL AFFILITION HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y WORKERS' COMP BOARD RATING Has your license to practice medicine ever bee Have your privileges or employment at any hear revoked or voluntarily surrendered? Have you ever been convicted of or pled guilty (If answering YES to any of County County	EAR ECFMG # (If en denied, suspended, alth care facility or entity of the above three (3) quarter county medical so and you to join? (Name) and for membership, the District Branch, and societies permission.	POSITION/SPECIAL DATE I SPECIALTY attended medical schoo revoked, or voluntarily su ty ever been denied, susp utes a misdemeanor or fe uestions, please attach a na ciety? I agree to comply with and the Medical Socie	ENTERED PR I abroad) urrendered? pended, terminelony? arrative with exp	nated, planation) When? rules and te of Nev	Yes Yes Yes Yes Yes Yes Yes Yes	No □ No □ No □ No □ tions of an provide
CURRENT HOSPITAL AFFILI HOSPITAL/LOCATION NYS LICENSE # D BOARD CERTIFIED? Y WORKERS' COMP BOARD RATING Has your license to practice medicine ever bee Have your privileges or employment at any hear revoked or voluntarily surrendered? Have you ever been convicted of or pled guilty (If answering YES to any Have you ever been a member of this or any of County Is there a member we can thank for encouraging the state of the county of Queens, fax and e-mail information, I give the medical society of the County of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information, I give the medical society of the county of Queens, fax and e-mail information.	EAR ECFMG # (If en denied, suspended, alth care facility or entity of the above three (3) quart that constituty of the above three (3) quart the county medical so eng you to join? (Name) and you to join? (Name) and for membership, the District Branch, and societies permission and web links."	POSITION/SPECIAL DATE I SPECIALTY attended medical schoo revoked, or voluntarily su ty ever been denied, susp utes a misdemeanor or fe uestions, please attach a na ciety? I agree to comply with and the Medical Socie	ENTERED PR I abroad) urrendered? pended, terminelony? arrative with exp	nated, planation) When? rules and te of Nev	Yes Yes Yes Yes Yes Yes Yes Yes	No □ No □ No □ No □ tions of an provide

<u>Mer</u>	nbership Fees						
□ Apply dues payment as indicated for QU □ Established Physician: (Full Dues - \$25 □ Associate Member Physician: *(Full due □ 1st Year Practice: □ 2nd Year Practice: □ Working Part-Time: (fewer than 20 hour □ Resident/Fellow: □ First District Branch Contribution □ MSSNYPAC Contribution: **(suggested)	O Queens County & \$460 is paid to another county) rs/week)	MSSNY)	\$710.00 \$150.00* \$480.00 \$480.00 \$480.00 \$45.00 \$5.00** \$50.00***				
* Associate Member has primary membership ir ** First District Branch Contribution help *** MSSNYPAC contribution of \$50 is <u>optional</u> , but su	os to support the programs that will	benefit the branch.					
Make check for the	full amount payable to "MSC	Q"					
Include with your application and full p	payment, a copy of your i	medical licen	se, registration				
certificate, curriculum vitae and proof o	of board certification (if a	pplicable). Pl	ease mail to:				
 Direct all questions to the Membership Comitia Meetings are on the 1st Tuesday Liability insurance is available through <i>MLMIC</i> is the physician-owned company 	y of the month at 7:30PM. the <i>Medical Liability Mutuc</i>	300. al Insurance Co a Medical Socie	- 0				
800.275.6564 - New York City or 800.356.4056 - Upstate							
TO PAY BY CREDIT CARD, PLEASE COMPLETE THE FORM BELOW							
CREI	OIT CARD FORM						
☐ Please charge: ☐ Visa ☐ MasterCard ☐ America	an Express	AMOUNT \$					
Card #	Expiration Date/	Sec Code					
Name on Card	_						
Billing Address							

County and State Membership is $\underline{unified}$. Physicians may join the county society where they $\underline{practice}$ or where they \underline{reside} . $\underline{1.01.2019}$

Date_____

Signature _____