SNOHOMISH COUNTY MEDICAL SOCIETY

Application for Membership

Identifying Information

Full Legal Name_____ MD/DO_____ DOB _____
Last First Middle

Residence Address: _____City _____Zip _____

Residence Phone: _____ Home E –mail _____

Gender _____ Citizenship _____ Birthplace _____

Marital Status _____ Spouse's Name_____

Practice Information

Type of Practice (i.e. group, clinic, solo, etc.) _____

Clinic/Group Name _____Affiliation Start Date _____

Office Address _____ City _____ Zip _____

Phone _____ Fax _____ E-mail _____

Current Hospital Affiliations _____

Previous Hospital Affiliations _____

_____

Specialty Information

Specialty _____ Board: ☐ Eligible Status _____
(primary)

☐ Certified Year _____

Specialty _____ Board: ☐ Eligible Status _____
(secondary)

☐ Certified Year _____

Medical License

Washington State License # _____ Date Issued _____
Other State Licenses:

State _____ License # _____ Date Issued _____

State _____ License # _____ Date Issued _____

Practice Experience

List in chronological order all previous practice experience. (Please include and explain any breaks or interruptions in time.)

1. _____
2. _____
3. _____
4. _____

Education & Training

Medical School _____

City/State _____ _____ Begin Date _____ End Date _____

Internship _____ **Specialty** _____

City/State _____ Begin Date _____ End Date _____

Internship _____ **Specialty** _____

City/State _____ Begin Date _____ End Date _____

Residency _____ **Specialty** _____

City/State _____ Begin Date _____ End Date _____

Residency _____ S**pecialty** _____

City/State _____ Begin Date _____ End Date _____

Fellowship _____ S**pecialty** _____

City/State _____ Begin Date _____ End Date _____

Professional Societies

Please list professional society memberships (i.e. AMA, specialty, etc.)

1. _____
2. _____
3. _____
4. _____

Required Information

Please check YES or NO to the following questions:

- Have you had any judgments or settlements made against you in professional liability cases, or are there any pending? (If yes, list details on a separate sheet of paper and provide a copy of the final judgment/outcome.) ☐ **YES** ☐ **NO**
- Have your privileges at any hospital ever been suspended, denied, diminished, revoked or not renewed? (If yes, list details on a separate sheet of paper and provide a copy of the final judgment/outcome.) ☐ **YES** ☐ **NO**
- Have you ever been denied membership or been subject to disciplinary action in any medical organization? (If yes, list details on a separate sheet of paper and provide a copy of the final judgment/outcome.) ☐ **YES** ☐ **NO**
- Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? (If yes, list details on a separate sheet of paper and provide a copy of the final judgment/outcome.) ☐ **YES** ☐ **NO**

I hereby apply for membership in the SCMS and agree to abide by the Bylaws and the Principles of Medicine Ethics for the organization. In consideration of the SCMS processing my application for membership, I grant permission and consent for their obtaining verification of the above information. I hereby release, and hold harmless from any liability or loss, the SCMS, 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 who, in good faith and without malice, provide information to the SCMS or to its authorized representatives concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further release from liability the SCMS, their officers, agents, employees, and members for the delivery of information to any third party as authorized herein, provided such delivery occurs prior to the acknowledged receipt, in the office of the SCMS, of a written notice of revocation of the release.

Signature _____ Date _____

Print Name _____

Photo Request

If you would like to have a photograph of yourself in the Snohomish County Medical Society Directory and Website, please submit, along with this application, a 2" x 3" photograph, preferably color or email your photo to LMK@wsma.org

Optional Information

Do you have a personal statement you would like to have appear on your website membership listing? (Clinical interests, practice philosophy, or special diseases/conditions you treat in your practice?)_____

_____

_____

_____

Does your practice have a website address that you would like to have linked from your SCMS Website Membership Listing?

If so, please provide the address in this space: _____

Referral/New Patient Instructions

Conditions/Limitations

Are you currently accepting new patients? ☐ YES ☐ NO _____

Are you accepting new Medicare patients? ☐ YES ☐ NO _____

Are you accepting new Medicaid Fee-for-Service patients? ☐ YES ☐ NO _____

Are you accepting new Medicaid Healthy Options patients? ☐ YES ☐ NO _____

Are you accepting new L&I patients? ☐ YES ☐ NO _____

Please list any other exceptions or exclusions

_____

_____

Multi-Lingual capabilities? _____

Please complete this application in its entirety and return it **with a copy of your Washington State License**.

If you have any questions regarding this application or approval process, please contact Linda Krause at the SCMS office at (206) 956-3624, or via e-mail addressed to LMK@wsma.org

Please return your completed application with a check for $150.00 (or fill out the credit card information below) and a copy of your Washington State License to:

SCMS Membership
2001 Sixth Avenue, Suite 2700
Seattle, WA 98121

Snohomish County Medical Society accepts Visa and Mastercard. Please fill out the credit card information below:

Name:_____
Address:_____
City, State, Zip code:_____

Name on the credit card:_____
Credit card number: _____
Expiration Date: _____/_____ 3 digit code on the back of the card: _____