



# Application for Membership

## Identifying Information

Full Legal Name \_\_\_\_\_ MD/DO/PA \_\_\_\_\_ DOB \_\_\_\_\_  
Last First Middle  
Residence Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Residence Phone: \_\_\_\_\_ Home E-mail \_\_\_\_\_

## 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 \_\_\_\_\_  
Residency \_\_\_\_\_ Specialty \_\_\_\_\_  
City/State \_\_\_\_\_ Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

## Professional Societies

Please list professional society memberships (i.e. AAPA, WAPA, 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

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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](mailto: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? \_\_\_\_\_

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 \$75.00 (or fill out the credit card information below) and a copy of your Washington State License to:

**SCMS Membership**  
**2033 Sixth Avenue, Suite 1100**  
**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: \_\_\_\_\_

Your annual Snohomish County Medical Society membership dues are \$75.00 per year.