



2175 K Street, NW
Suite 200
Washington, DC 20037-1841

Telephone: 202.466.1800
Fax: 202.452.1542
<http://www.msdc.org>

APPLICATION FOR MEMBERSHIP – 1st year \$270*

BIOGRAPHICAL DATA

Name _____ SS # _____

Primary Office Address _____

Group Practice Name/Associates (if applicable) _____

Office phone _____ Office fax _____ Email _____

Specialty _____ Hospital privileges _____

Home address _____

Home phone _____ Home fax _____

Prefer mail by 1st class _____ Fax _____ Email _____

Preferred mailing address Office _____ Home _____ Preferred billing address Office _____ Home _____

Date of Birth _____ Place of Birth _____

Male _____ Female _____ Spouse's name (if married) _____

Foreign Language (s) spoken (including sign language) _____

I am an AMA member Yes _____ No _____ I want to join the AMA Yes _____ No _____

Please list the activities, projects, or issues in which you feel the Medical Society should be involved or can assist you in your practice.

OBLIGATION FOR MEMBERSHIP

I certify that to the best of my knowledge, the information that I have provided in this application is true and accurate. If elected to membership, I hereby agree to be governed by the Constitution and Bylaws of the Medical Society of the District of Columbia, and to abide by the regulations prescribed therein. Also, I hereby authorize the release of any information concerning my character, reputation, ability, medical practice or conduct by any medical society, hospital, licensing authority, medical school, peer review committee, or individual to the Medical Society of the District of Columbia and agree to hold harmless any person or organization making such release, as long as such release is made in good faith and without malice.

I understand that by providing my mailing address, email address, telephone number and fax number I consent to receive communications sent by or on behalf of MSDC (and its subsidiaries and affiliates) via regular mail, email, telephone, or fax. I understand that MSDC may share my address/email/telephone/fax with other organizations.

Signature of Applicant _____ Date _____

CREDIT CARD AUTHORIZATION

MasterCard, Visa, Am Exp, Discover

Name _____ Expiration date on Charge Card _____

Charge Account No _____

Cardholder Signature _____ Date _____

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