Wisconsin Medical Society

Your Doctor. Your Health.

Application for Membership

I make my application in the ______________________________ County Medical Society and the Wisconsin Medical Society.

Name: ____

Designation: ❑ MD ❑ DO

WI License: ________________________

Gender: ❑ Male ❑ Female

Birth Date: _________________________

Home Address:

Address: ____

City: _______________________ State: ______ ZIP: _________

Home Phone: ______________________________

Work Phone: _______________________________

Fax: _______________________________________

E-Mail Address: ____________________________

Clinic Address:

Clinic Name: ____

Clinic Start Date (if new to clinic): ___________

Address: ____

City: ______________________ State: ______ ZIP: _________

Preferred Mailing Address: ❑ Home ❑ Clinic

Education and Certifications:

Medical School: ____

Year Graduated______________________________

Residency Location(s):____

Year Completed: ____________________________

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Fellowship: ____

Year Completed: ____________________________

Primary Specialty: ____

Secondary Specialty: ____

Board Certification: ____

(Continued on next page)

If you answer yes to any of the following questions, please attach a written explanation.

Yes	No	
❏	❏	Have you ever been convicted of a felony crime related to medical practice within the last 5 years?
❏	❏	Has your license to practice medicine in any jurisdiction ever been limited, voluntarily surrendered, suspended or revoked?
❏	❏	Have you ever been the subject of any disciplinary action by any medical society, specialty society or hospital staff?
❏	❏	Have any settlements or judgments of malpractice claims been paid by you or on your behalf by another entity?
❏	❏	Have you ever had an application for membership in any medical or specialty society rejected?

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the County Medical Society, the Wisconsin Medical Society and the American Medical Association. I agree to notify the societies of any changes in licensure status due to disciplinary action or involuntary loss of license.

I hereby release, and hold harmless, from any liability or loss including attorney fees, the County Medical Society, Wisconsin 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, 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 their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership. All information submitted by me in this application is true to the best of my knowledge and belief. I understand that any significant misstatement in, or omissions from, this application may constitute cause for denial of membership.

Signature: ____ Date: ______________________

Please mail this application to: Wisconsin Medical Society, PO Box 1109, Madison, WI, 53701-1109 or fax it to 608.442.3802.