



Wisconsin Medical Society

Your Doctor. Your Health.

Student Application for Membership

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

Name: _____

Birth Date: _____

Gender: Male Female

Current Address:

Address: _____

City: _____ State: _____ ZIP: _____

Permanent Address (if different):

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____

Work Phone: _____

Fax: _____

E-Mail Address: _____

Medical School: _____

Year Started Medical School: _____

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 to 608.442.3802.