

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 _____ **Specialty** _____
City/State _____ Begin Date _____ End Date _____

Fellowship _____ **Specialty** _____
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 WSMA and SCMS and agree to abide by the Bylaws and the Principles of Medicine Ethics for each organization. In consideration of the WSMA/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 WSMA and 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 WSMA and SCMS or to its authorized representatives concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further release from liability the WSMA and 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 WSMA and/or 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 bjw@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**. The SCMS is a unified county medical society. Membership in the SCMS requires membership in the WSMA and or WOMA.

If you have any questions regarding this application or approval process, please contact the SCMS office at 1-800-532-4139, or via e-mail addressed to JAL@wsma.org.

Please return your completed application and a copy of your license to the following address:

SCMS/WSMA Membership
2033 Sixth Avenue, Suite 1100
Seattle, WA 98121