APPLICATION FOR MEMBERSHIP

STARK COUNTY MEDICAL SOCIETY

4942 Higbee Avenue, Suite L, Canton, Ohio 44718 PHONE: 330.492.3333

Please *complete* THE BLUE SECTIONS ONLY and sign this application for membership in the Stark County Medical Society. Return to the Society. Thank you!

Membership Category: ☐ Active (Full-Time) ☐ Part-Time (<20 hrs./week)

NAME: Medical Education NA DPM

GROUP NAME:

OFFICE ADDRESS:

OFFICE PHONE: FAX: EMAIL:______________________________

HOME ADDRESS, CITY & ZIP: ____

HOME PHONE: ____________ SPOUSE ______________ DATE OF BIRTH

PREFERRED MAILING ADDRESS: ☐ HOME or ☐ OFFICE

MEDICAL EDUCATION AND TRAINING:

MEDICAL SCHOOL: DATE OF GRADUATION:

SPECIALTY: SUB-SPECIALTY: _________________________

BOARD CERTIFIED: ________________________ YEAR: ____________________________________

Residency/Fellowship HOSPITAL/INSTITUTIONS CITY STATE: DATES

RESIDENCY:____

MEDICAL LICENSURE:

STATE: OHIO CERTIFICATION NUMBER : EXPIRATION

PREVIOUS OHIO COUNTY MEDICAL SOCIETY MEMBERSHIP HELD IN (if applicable)

____

CURRENT HOSPITAL STAFFS (PLEASE CHECK ALL THAT APPLY): ☐ AULTMAN

☐ CLEVELAND CLINIC MERCY MEDICAL CENTER ☐ Other:____________________________________

Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a licensing agency; or have you ever surrendered your license? ☐ YES ☐ NO

I hereby certify that I am a legally registered physician, residing or practicing in Stark County in the state of Ohio and that I have not been convicted of a felony. If accepted as a member, I agree to abide by the Constitution and Bylaws of the SCMS.

*SIGNATURE*____ *DATE*_________________