King County Medical Society

Membership Application

Please **TYPE** or **PRINT**. Attach additional sheets if necessary

PERSONAL INFORMATION

DOCUMENTS REQUIRED: Copies of board certifications and a color photo

Last Name _____ First Name _____ Initials _____ Suffix _____

MD/DO _____ Other Academic Degrees _____ Birthdate _____

Birthplace (City/State) _____ Citizenship _____ Gender _____

Home Address _____ Spouse/Partner _____

City _____ State _____ Zip _____ Phone _____

Email _____ Publish my email on website? ☐ Yes ☐ No

What languages are you fluent in other than English? 1. _____ 2. _____

PRACTICE INFORMATION

REQUIRED: Name of clinic and/or group

PRIMARY PRACTICE: Type of practice ☐ Group Clinic ☐ Solo ☐ Other

Clinic/Group Name _____

Office Address _____

City _____ State _____ Zip _____ Phone _____

Email _____

SECONDARY PRACTICE: Type of practice ☐ Group Clinic ☐ Solo ☐ Other

Clinic/Group Name _____

Office Address _____

City _____ State _____ Zip _____ Phone _____

Email _____

I prefer to receive King County Medical Society mail at: ☐ Primary office ☐ Secondary office ☐ Home

Practice Manager Name _____ Phone _____ Email _____

Practice description (100 words or less) _____

Insurance Accepted: ☐ Medicare ☐ Medicaid ☐ Other

If other, name state (up to 4) _____

MEDICAL LICENSING

Washington State License # _____ Date Issued _____

Other State Licenses # _____ Date Issued _____

SPECIALTY

Primary Specialty _____ Board: ☐Eligible ☐Certified ☐Neither

Secondary Specialty or Special interest: _____ Board: ☐Eligible ☐Certified ☐Neither

Please note: *You Primary Specialty must be an ABMS approved listing. A Special Interest is a practice focus or clinical interest which you may specify. A total of 3 listings are allowed*

Practicing in King County as of _____ Is this your first year of practice? ☐Yes ☐No

EDUCATION & TRAINING

Medical School Name _____ State _____ Year Graduated _____

Internship Institution _____ State _____ Began _____ Ended _____

Specialty _____

Residency Institution _____ State _____ Began _____ Ended _____

Specialty _____

Additional Training _____ State _____ Began _____ Ended _____

Course of Study _____

Foreign medical school graduates: ECFMG certificate # _____ Date Issued _____

PROFESSIONAL & PRACTICE EXPERIENCE

Please list professional society memberships (e.g. AMA, WSMA, specialty, etc)

Are you transferring from an AMA component medical society? ☐ Yes ☐ No

If Yes, which one? _____

List in chronological order all practice experience. If there is a gap in your practice due to military, pregnancy, etc, please include time frame

ADDITIONAL QUESTIONS

☐Yes ☐No Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, denied, not renewed or have proceedings toward any of those ends ever been instituted? If yes, list details below.

☐Yes ☐No Have your privileges at any hospital ever been suspended, denied, diminished, revoked or not renewed? If yes, list details below.

☐Yes ☐No Are there any medical malpractice actions in this or any other state pending against you presently? If yes, list details below.

☐Yes ☐No Have any judgments or settlements been made against you in professional liability cases in the last 10 years? If yes, list details below.

☐Yes ☐No Have you ever been denied professional liability insurance or has your policy ever been canceled. If yes, list details below.

RELEASE FOR MEMBERSHIP TO KING COUNTY MEDICAL SOCIETY

Please complete the following section

In consideration of the King County Medical Society processing my application for membership, I grant permission and consent for you to obtain from all hospital affiliations, information regarding staff privileges, and actions relating thereto; and all information from former medical society affiliations, specialty organizations, the American Medical Association and the Washington State Medical Association, medical schools and other organizations providing medical training including internship and residencies.

I agree to furnish the Society with all information relative to any claim or action filed against me for malpractice, and I authorize and consent for you to obtain from my insurance malpractice carrier any and all information regarding insurance coverage, premiums, claims, and actions against me.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character, and ethical qualifications to all hospitals, and medical licensing or discipline boards who request such information.

I hereby release, and hold harmless from any liability or loss, the King County Medical Society, its 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, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the Medical Society, or to its authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further release from liability the King County Medical Society, its 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 King County Medical Society, of a written notice or revocation of this release.

I hereby agree to abide by the By-Laws and the Principles of Medical ethics of the KCMS and agree upon approval of membership, that my membership in the KCMS shall be conditional upon continued compliance of the aforementioned; and I further agree to recognize and abide by the interpretation thereof by the authorized officers of the Society, reserving all rights of appeal as set forth in the By-Laws of this Society.

I HEREBY AFFIRM AND REPRESENT THAT ALL STATEMENTS, ANSWERS, AND INFORMATION CONTAINED IN THIS APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I declare under penalty of perjury under the laws of the State of Washington that all statements, answer and information contained in this application are true and correct.

Please sign and date

Applicant signature _____ Date _____

HOW TO SEND US YOUR COLOR PHOTO

A recent photograph is required with your application. You can send one by mail or electronically.

- Send by mail: KCMS, 200 Broadway, Seattle WA 98122
- Send electronically: Send a jpg with your application or separately you can mail to: info@kcmsociety.org
- Specifications: A color portrait. jpg or tif format. 300 dpi resolution. No larger than 5”x7”.