King County Medical Society

Membership Application

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

PERSONAL INFORMATION DOCUMENTS REQUESTED: A color photo

Last Name_____First Name_____Middle Initial_____Suffix_____

MD/DO_____Other Academic Degrees_____Birthdate_____

Primary Mailing Address_____

City_____State_____Zip_____Phone _____

Primary Email_____

PRACTICE INFORMATION REQUIRED: Name of clinic and/or group

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

Clinic/Group Name _____

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

Clinic/Group Name _____

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 _____

Secondary Specialty or Special interest: _____

Practicing/Residing in King County as of_____Is this your first year of practice? ☐ Yes ☐ No

EDUCATION & TRAINING

Medical School Name_____State_____Year Graduated _____

Residency Institution_____State_____Began_____Ended_____

Specialty _____

Additional Training_____State_____Began_____Ended_____

Course of Study _____

MEMBERSHIP DUES PAYMENT

☐ Make checks payable to King County Medical Society or Credit Card: ☐ MasterCard ☐ Visa

Card Number _____Exp. Date _____CVC Code_____

HOW TO SEND US YOUR PHOTO (Optional)

A recent photograph is requested 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”.