



- APPLICATION FOR MEMBERSHIP -

**MEDICAL SOCIETY OF THE STATE OF NEW YORK  
AND THE MEDICAL SOCIETY OF THE COUNTY OF WESTCHESTER**  
333 Westchester Avenue • Suite LN 01 • White Plains NY 10604 • 914-967-9100

*County and state membership is unified. Physicians may join the county society where they practice or where they reside.*

Check if also applying to the AMERICAN MEDICAL ASSOCIATION (dues on reverse)

NAME \_\_\_\_\_  
Last First MI Jr./Sr.

HOME ADDRESS (H) \_\_\_\_\_  
City State Zip

HOME TEL ( ) \_\_\_\_\_ HOME FAX ( ) \_\_\_\_\_

GROUP NAME (if applicable) \_\_\_\_\_ Group manager's Email \_\_\_\_\_

OFFICE ADDRESS (O) \_\_\_\_\_

Send mail to  H  O \_\_\_\_\_  
City State Zip

OFFICE TEL ( ) \_\_\_\_\_ OFFICE FAX ( ) \_\_\_\_\_

E-MAIL \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  Male  Female

MEDICAL SCHOOL \_\_\_\_\_ YEAR OF GRADUATION \_\_\_\_\_  MD  DO

DATE OF COMPLETION OF RESIDENCY/FELLOWSHIP \_\_\_\_\_ OTHER DEGREES \_\_\_\_\_

CHECK IF WORKING FEWER THAN 20 HOURS/WEEK  NAME OF SPOUSE \_\_\_\_\_

**CURRENT HOSPITAL AFFILIATIONS** (if none, please list any HMO affiliations and provide your CV.)

HOSPITAL/LOCATION	POSITION/SPECIALTY
_____	_____
_____	_____
_____	_____

NYS LICENSE # \_\_\_\_\_ DATE GRANTED \_\_\_\_\_ DATE ENTERED PRACTICE \_\_\_\_\_

BOARD CERTIFIED? \_\_\_\_\_ YEAR \_\_\_\_\_ SPECIALTY \_\_\_\_\_

WORKERS' COMP BOARD RATING \_\_\_\_\_ ECFMG # (if attended medical school abroad) \_\_\_\_\_

ARE YOU ACCEPTING NEW PATIENTS?  Yes  No

Yes  No Has your license to practice medicine ever been denied, suspended, revoked, or voluntarily surrendered?

Yes  No Have your privileges or employment at any health care facility or entity ever been denied, suspended, terminated, revoked or voluntarily surrendered?

Yes  No Have you ever been convicted of or pled guilty to any act that constitutes a misdemeanor or felony?

Have you ever been a member of this or any other county medical society? \_\_\_\_\_ County \_\_\_\_\_ When? \_\_\_\_\_

Is there a member we can thank for encouraging you to join? (Name) \_\_\_\_\_

**PHYSICIAN'S ATTESTATION:** "In applying for membership, I agree to comply with the bylaws, rules and regulations of the county society, the district branch, and the Medical Society of the State of New York. In providing fax and e-mail information, I give the medical societies permission to send me news updates, important legal/legislative notices, seminar invitations, advertisements and web links."

PLEASE CHECK HERE TO INDICATE AGREEMENT  DATE \_\_\_\_\_

**My dues payment is provided as indicated for WESTCHESTER COUNTY and MSSNY membership – 2008:**

**Established Physician: \$795**     **Young Physician** (under age 40 or in first 5 yrs. of practice): **\$210\***  
\*increases gradually over 3 years.

**Resident/Fellow: \$35**     **Working Part-time** (fewer than 20 hours/week): **\$402**

(Make check payable to "Medical Society" or use the form on the reverse for credit card payment. Thank you.)

The county society may require additional information

**TO PAY BY CREDIT CARD, PLEASE COMPLETE THE FORM BELOW**

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1. You may also apply to the AMERICAN MEDICAL ASSOCIATION (AMA) with this application, simply by including the dues. Although it is optional, we urge you to extend your membership to the national arm of your federation of organized medicine.

**AMA DUES**

<b>FULL</b>	<b>2<sup>nd</sup> YEAR PRACTICE</b>	<b>1<sup>st</sup> YEAR PRACTICE</b>	<b>RESIDENT/ FELLOW</b>
\$420	\$315	\$210	\$45

2. Please submit one dues check for the appropriate total, made payable to the **Medical Society**. If you prefer to pay by credit card, please complete the form below.
3. Submit your application, registration certificate and dues in the envelope provided addressed to the Medical Society of the State of New York, or to your county medical society.
4. Medical liability insurance is available through the **Medical Liability Mutual Insurance Company**, the physician-owned company established by your state medical society in 1975. Full information can be obtained by contacting the company at 2 Park Avenue, Room 2500, New York, NY 10157-0505; telephone 1-800-275-6564 (metropolitan New York) or 1-800-356-4056 (upstate).

5. Please address any questions to the MSSNY Division of Membership:

**Medical Society of the State of New York**

**420 Lakeville Road**

**POB 5404**

**Lake Success NY 11042**

**800-523-4405 x 403**

**516-488-6100 x 403**

**FAX: 516-616-9285**

Please charge:  Visa     MasterCard     American Express     Discover    **AMOUNT \$** \_\_\_\_\_

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on Card \_\_\_\_\_ Signature \_\_\_\_\_