Lane County Medical Society

P.O. Box 7192 Springfield OR 97475 || (541) 686-0995 || Fax (541) 687-1554 || info@lcmedsociety.com

Membership Application

Practice Information (Required) **Estimated Start Date:**_____ **NPI #** _____

Physician Name _____ ☐ **M.D.** ☐ **D.O.**
First Name *M.I.* *Last Name*

Group Name/Medical Group _____ **Office Manager** _____

Primary Address _____
Street/P.O. Box *Suite #* *City* *State* *Zip*

Primary Office PH# _____ **Primary Office Fax#** _____ **E-mail Address** _____

Education and Licensing Information (Required)

Specialty _____ **Board Certified?** *Yes* *No* *Eligible*

Subspecialty 1 _____ **Subspecialty 2** _____ **Board Certified?** *Yes* *No* *Eligible*
ABMS (American Board of Medical Specialties) specialties.

Medical School _____ **Year of Graduation** _____
Facility Name *City* *State*

Internship _____ **From**____/____/_____ **To** ____/____/_____
Facility Name *City* *State* *Mo. Day Yr.* *Mo. Day Yr.*

Residency _____ **From**____/____/_____ **To** ____/____/_____
Facility Name *City* *State* *Mo. Day Yr.* *Mo. Day Yr.*

Fellowship _____ **From**____/____/_____ **To** ____/____/_____
Facility Name *City* *State* *Mo. Day Yr.* *Mo. Day Yr.*

Oregon Licensure Date _____ **License #** _____ **(Please attach a copy.)**

Have you been subject to disciplinary review or action by either of the following?
State Board of Medical Examiners *Yes* *No* County or State Medical Society *Yes* *No* (If 'yes', please attach explanation.)

Personal Information (Required) ☐ **Male** ☐ **Female**

Birthplace _____ **Birthdate** ____/____/____ **Language(s) spoken** _____

Spouse/Spousal Equivalent Name _____ **Cell Phone** _____

Home Address _____ **Home Phone** _____

Emergency Name/Contact # _____ **Personal Email Address** _____

I, _____ **(*please print*) hereby apply for membership in the Lane County Medical Society and agree to abide by its bylaws and policies and the Principles of Medical Ethics as promulgated by the American Medical Association.**

Signed _____ **Date**____/____/_____

Membership Classification (check one)

	☐ *Active*	☐ *Associate*	☐ *Part-time*	☐ *Retired, Resident/Intern & Inactive*
Annual Dues:	**$295**	**$221.25**	**$221.25**	**$35.00**

(For status definitions, please see attachment)

Membership Payment

Membership Classification Amount: **$**_____

Additional optional tax-deductible donation to the LCMS Provider Wellness Program *(A program that enhances the well-being of physicians)*: **$**_____

Office Use Only:
Date Paid:_____
Approved:_____

Total Amount Enclosed: **$** _____

Please make checks payable to Lane County Medical Society or:

VISA *MASTERCARD* _____ *Exp. Date* _____ *Signature* _____

***NOTE: In order to complete your membership application, (1) please attach a copy of your Oregon medical license and (2) email a professional (300 dpi) photo to info@lcmedsociety.com**