

APPLICATION FOR MEMBERSHIP IN THE LINN COUNTY MEDICAL SOCIETY

FULL NAME: _____ Male Female

CLINIC NAME: _____
 Telephone # _____

ADDRESS: _____
 Street City Zip Fax #

RESIDENCE: _____
 Street City Zip Telephone #

BIRTH: _____
 City State or Country Birth Date

MARITAL STATUS: Single Married - Spouse's Name: _____

Has your license to practice medicine ever been denied, suspended or revoked by any government agency? Yes No
 If yes, indicate where, when and why:

DATE LICENSED IN IOWA: ____/____/____ LICENSE NUMBER: _____

OTHER STATES LICENSED: _____

1ST SPECIALTY: _____ BOARD CERTIFIED: Yes No DATE: ____/____/____

2ND SPECIALTY: _____ BOARD CERTIFIED: Yes No DATE: ____/____/____

IF CERTIFIED, WHAT BOARDS(S)? _____

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RECORD OF MEDICAL EDUCATION AND PRACTICE

Chronological account of applicant's training, military service and practice since graduation from medical school. Include internship, residency and postgraduate study. Please leave no unexplained interval in sequence of dates, or attach explanation.

| UNDERGRADUATE/ MEDICAL COLLEGE | PLACE AND LOCATION | POSITION HELD | DATES | | DEGREE |
|-----------------------------------|--------------------|---------------|-------|----|--------|
| | | | FROM | TO | |
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PRESENT HOSPITAL AND CLINIC AFFILIATIONS:

In applying for membership, I agree to comply with the Articles and Bylaws, rules and regulations of the county medical society and to adhere to the ethical principles of the organization. Unless otherwise indicated, professional information may be given to others outside of the county medical society.

_____ Date

_____ Applicant's Signature