Marion-Polk County Medical Society

ADVOCATE. COLLABORATE. EDUCATE.

Membership Application

Your application fee of $50 must accompany this form.
Please enclose a current photograph.

NAME

First _____ M. ____ Last _____ Title _____

OFFICE

Office Name _____ Date joining/joined _____

Address _____ City _____ Zip _____

Telephone _____ Fax _____

Office Manager_____ Office Manager email_____

Do you wish to be placed on the referral service as accepting new patients? ❑ YES ❑ NO

Fluent in any other languages? _____

PERSONAL

Date of Birth _____ Birthplace _____ Spouse/Partner's Name_____

Home Address _____ City _____ State ____ Zip _____

Home Telephone _____ Home / Office Email address _____

PROFESSIONAL (please complete as applicable)

Medical School _____ City _____ State ____ Graduate Year _____

Physician Assistant Program _____ City _____ State ____ Graduate Year _____

Nursing School _____ City _____ State _____ Graduate Year _____

Internship_____ City _____ State ____ Dates to-from _____

Residency _____ City _____ State ____ Dates to-from _____

Fellowship _____ City _____ State ____ Dates to-from _____

Specialty _____ Date of Board Certification _____

Subspecialty _____ Date of Board Certification _____

Date of Oregon License _____ License Number_____

Current Hospital Affiliation(s) _____

Current Professional Affiliation(s) _____

■■■ PREVIOUS PRACTICE

Practice
Dates To-From _____ Address _____ City _____ State _____

Practice
Dates To From _____ Address _____ City _____ State _____

Practice
Dates To-From _____ Address _____ City _____ State _____

■■■ OTHER

Have you ever been subject to disciplinary review or action by a state Board of Medical Examiners, Board of Nursing or a county or state medical society? ❑ NO ❑ YES If YES, please attach explanation.

Previous Medical/Nursing Society Membership _____ City _____ State _ Dates To-From _____

Previous Hospital Affiliation _____ City _____ State _____ Dates To-From _____

I hereby apply for membership in the MPCMS, I agree to abide by its ByLaws and the Principles of Medical Ethics. I also agree to cooperate fully with any grievance or peer review investigation conducted by the MPCMS Medical Review Committee and acknowledge that failure to do so may constitute grounds for disciplinary action.

SIGNATURE _____ DATE OF APPLICATION _____

Membership Classification
Check appropriate box.

DO NOT include your dues payment. **Enclose ONLY your $50 application fee with this form.**
Dues will be invoiced after the Board of Directors approves your membership.

ACTIVE I.....❑
•First Year of practice in the local area – $273.75 - 25% discount to Annual Dues

ACTIVE .....❑
•Established physician joining the Society – Annual Dues $365.00

ACTIVE-LIMITED/SEMI-RETIRED.....❑
•Practicing not more than 20 hours per week - Annual Dues $165.00

PHYSICIAN ASSISTANT/ADVANCED PRACTICE NURSE.....❑
•Annual Dues $150.00

Please return application to MPCMS. If you have any questions, please call 503-362-9669.
Marion-Polk County Medical Society ● 4985 Battle Creek Road SE, Suite 130 ● Salem, OR 97302