



**St. Louis Metropolitan Medical Society**  
 680 Craig Rd., Ste. 308 • Saint Louis, MO 63141-7120  
 (314) 989-1014 • FAX (314) 989-0560

## APPLICATION FOR MEMBERSHIP

Male  Female

|                         |            |        |              |            |
|-------------------------|------------|--------|--------------|------------|
| LAST NAME               | FIRST      | MIDDLE |              |            |
| OFFICE ADDRESS - STREET | CITY/STATE | ZIP    | PHONE NUMBER | FAX NUMBER |
| HOME ADDRESS - STREET   | CITY/STATE | ZIP    | PHONE NUMBER |            |

For mailing please use:  office address  home address E-Mail address \_\_\_\_\_

Birth \_\_\_\_\_ Spouse \_\_\_\_\_  
DATE PLACE

|                   |              |           |
|-------------------|--------------|-----------|
| Medical Education | SCHOOL NAME  | LOCATION  |
| DEGREE            | FROM: MO/YR. | TO: MO/YR |

Place and Type of Service and/or Training

Internship: \_\_\_\_\_  
PLACE FROM: MO/YR TO: MO/YR

Residency: \_\_\_\_\_  
PLACE FROM: MO/YR TO: MO/YR

Fellowship: \_\_\_\_\_  
PLACE FROM: MO/YR TO: MO/YR

Missouri License: \_\_\_\_\_ Other: \_\_\_\_\_

Active Hospital Appointments (list dates):  
 (1) \_\_\_\_\_  
 (2) \_\_\_\_\_ (3) \_\_\_\_\_  
 (4) \_\_\_\_\_ (5) \_\_\_\_\_

Teaching Appointments (list dates): \_\_\_\_\_

Medical Specialty: \_\_\_\_\_ Date Certified: \_\_\_\_\_  
 Subspecialty: \_\_\_\_\_ Date Certified: \_\_\_\_\_

Type of Practice: (Check appropriately)

Office Based: Solo  Hospital Based  Government  HMO   
 Office Based: Group  Teaching/Research  Other (Specify)  \_\_\_\_\_

Are you a current AMA member:  Yes  No  
 Are you a current MSMA member:  Yes  No

Specialty Society Memberships: \_\_\_\_\_

(COMPLETE REVERSE SIDE)

Within the last 5 years, have you been convicted of a felony crime?  Yes  No  
If yes, please provide full information.

Within the last 5 years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?  Yes  No  
If yes, please provide full information.

Within the last 5 years, have you been the subject of any disciplinary action by any medical society or hospital staff?  Yes  No  
If yes, please provide full information.

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the St. Louis Metropolitan Medical Society, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
PLEASE PRINT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Name of SLMMS' member to contact as sponsor

| 2010 MEMBERSHIP DUES – SLMMS   |        | TOTAL |
|--|--------|-------|
| <b>JUNIOR</b><br><i>Physician in a training program - Internship, Residency, or Fellowship</i> | \$40   |       |
| <b>ACTIVE</b><br><i>First year in practice following training program</i>                      | \$165  |       |
| <i>Second year in practice following training program and thereafter</i>                       | *\$330 |       |
| <b>2010 MEMBERSHIP DUES – MSMA (OPTIONAL)</b>  | \$380  |       |

Make *ONE* check payable to: *St. Louis Metropolitan Medical Society* OR charge MasterCard or Visa.

|  |       |
|--|-------|
| *First-year full SLMMS membership dues are prorated as follows (active members only) |       |
| January – March  | \$330 |
| April – June   | \$248 |
| July – September   | \$165 |
| October – December   | \$83  |

Charge your dues payment to your  
 MasterCard or  Visa  
Account Number \_\_\_\_\_  
Expiration Date \_\_\_\_\_  
Amount of Dues\$ \_\_\_\_\_

Single payment or  Installment payments

\_\_\_\_\_  
Signature required

\_\_\_\_\_  
Print Name

Mail to:  
St. Louis Metropolitan Medical Society  
680 Craig Road, Suite 308  
St. Louis, MO 63141