



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

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 (optional)

2016 MEMBERSHIP DUES – SLMMS	
STUDENT <i>Student enrolled in accredited medical school</i>	Free
RESIDENT/FELLOW <i>Physician in a training program - Internship, Residency, or Fellowship</i>	\$25
ACTIVE <i>First year in practice following training program</i>	\$175
<i>Second year in practice following training program and thereafter</i> ¹ Includes an optional \$20 gift to the St. Louis Society for Medical and Scientific Education (SLSMSE)	¹ \$370

Make *ONE* check payable to: *St. Louis Metropolitan Medical Society* OR pay by credit card.

First-year full SLMMS membership dues are prorated as follows (active members only)	
January – June	² \$370
July – October	² \$195
² Includes an optional \$20 gift to SLSMSE	

Charge your dues payment to your
 MasterCard Visa AMEX Discover
 Account Number _____

Expiration Date _____

Amount of Dues\$ _____

 Signature required

 Print Name

Mail to:

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