– APPLICATION FOR MEMBERSHIP –

MEDICAL SOCIETY OF THE COUNTY OF ERIE
AND THE MEDICAL SOCIETY OF THE STATE OF NEW YORK

1317 Harlem Road • Buffalo NY 14206 • 716-852-1810

County and state membership is unified. Physicians may join the county society where they practice or where they reside.

NAME _____
Last *First* *MI* *Jr./ Sr.*

E-MAIL _____ DATE OF BIRTH _____ ❑ Male ❑ Female

HOME ADDRESS (H)_____
City *State* *Zip*

HOME TEL (____) _____ **Send mail to ❑ H ❑ O**

GROUP NAME (If applicable) _____

Office Manager's Name_____ Office Manager's Email _____

OFFICE ADDRESS (O)_____
City *State* *Zip*

PRACTICE WEBSITE:_____

OFFICE TEL (____) _____OFFICE FAX (____) _____

NYS LICENSE # _____ DATE GRANTED _____ DATE ENTERED PRACTICE _____

BOARD CERTIFIED? _____ YEAR _____SPECIALTY _____

ECFMG # (If attended medical school abroad) _____

MEDICAL SCHOOL _____ YR OF GRADUATION __ ❑ MD ❑ DO ❑MBBS

Please attach: Curriculum Vitae _____ Recent Photo (Head Shot) _____ NYS Registration Certificate_____

CHECK IF WORKING FEWER THAN 20 HOURS/WEEK ❑ NAME OF SPOUSE _____

ARE YOU ACCEPTING NEW PATIENTS? ❑ Yes ❑ No Do you make house calls? ❑ Yes ❑ No

Have you ever been a member of this or any other county medical society? ❑ **Yes** ❑ **No** County _____ Year? _____

Is there a member we can thank for encouraging you to join? *(Name)*_____

❑ Yes ❑ No Has your license to practice medicine ever been denied, suspended, revoked, or voluntarily surrendered?
❑ Yes ❑ No Have your privileges or employment at any health care facility or entity ever been denied, suspended, terminated, revoked or voluntarily surrendered?
❑ Yes ❑ No Have you ever been convicted of or pled guilty to any act that constitutes a misdemeanor or felony?

PHYSICIAN'S ATTESTATION: I understand that any knowingly false statements could be grounds for revocation of membership in MSSNY and the county medical society. I agree to comply with the principles of medical ethics and with the bylaws, rules and regulations of each organization to which I am applying. I give the medical societies permission to send me news updates, important legal/legislative notices, seminar invitations, advertisements and web links via fax and email.

PLEASE SIGN HERE TO INDICATE AGREEMENT _____DATE _____

Please see reverse side for payment information

My dues payment is provided as indicated for **ERIE COUNTY** and **MSSNY** membership – **2020:**

- ❑ **Established Physician: $815**
- ❑ **Resident/Fellow: $63**
- ❑ **Young Physician** (under age 40 or in first 5 yrs. of practice)**: $200***
  *Increases gradually over 3 years.
- ❑ **Working Part-time** (fewer than 20 hours/week): **$415**

OTHER RECOMMENDED, VOLUNTARY ASSESSMENTS:

❑**MSSNY PAC $175** ❑**MESF $50**

A major share of Medical Society dues may be tax-deductible as a business expense. Check with your accountant for exact details. (Make check payable to "Medical Society" or use the form on the reverse for credit card payment. Thank you.)

TO PAY BY CREDIT CARD, PLEASE COMPLETE THE FORM BELOW

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1. Please submit one dues check for the appropriate total, made payable to the **Medical Society**. If you prefer to pay by credit card, please complete the form below. A major share of Medical Society dues may be tax-deductible as a business expense. Check with your accountant for exact details.

2. Submit your application, registration certificate, Curriculum Vitae, photo and dues in the envelope provided addressed to the Medical Society of the State of New York, or to your **county medical society**.

3. Medical liability insurance is available through the **Medical Liability Mutual Insurance Company**, the physician-owned company established by your state medical society in 1975. Full information can be obtained by contacting the company at 2 Park Avenue, Room 2500, New York, NY 10157-0505; telephone 1-800-275-6564 (metropolitan New York) or 1-800-356-4056 (upstate).

4. Please address any questions to the Erie County Medical Society Membership Director, Tineke Hall.

Erie County Medical Society
1317 Harlem Rd
Buffalo, NY 14206
(716) 852-1810 ext. 105
(716) 852-2930 – FAX
hallt@wnydocs.org

Please charge: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover **AMOUNT $** _____

Card # _____ Expiration Date _____

Name on Card _____ Security Code _____

Billing Address _____

Signature _____ Billing zip code _____