



- 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 • 716-852-1811

*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** \_\_\_\_\_

**My dues payment is provided** as indicated for **ERIE COUNTY** and **MSSNY** membership – **2017**:

- Established Physician: \$805**     **Young Physician** (under age 40 or in first 5 yrs. of practice): **\$200\***  
\*Increases gradually over 3 years.
- Resident/Fellow: \$53**     **Working Part-time** (fewer than 20 hours/week): **\$405**

**OTHER RECOMMENDED, VOLUNTARY ASSESSMENTS:**

- MSSNY PAC \$175**                       **MESF \$50**

**DISCOUNTED PRE-PAID LEGAL SERVICES**  **\$245**     **\$325 PREMIER PROGRAM**

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.)

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**TO PAY BY CREDIT CARD, PLEASE COMPLETE THE FORM BELOW**

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

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Please charge:  Visa     MasterCard     American Express     Discover    **AMOUNT \$** \_\_\_\_\_

Card # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on Card \_\_\_\_\_ Security Code \_\_\_\_\_

Billing Address \_\_\_\_\_

Signature \_\_\_\_\_ Billing zip code \_\_\_\_\_