



Medical Society of Johnson & Wyandotte Counties

6405 Metcalf, Suite 507, Shawnee Mission, KS, 66202 • 913.432.9444 • Fax: 913.432.9004

date: _____ male female

name: _____
last, first, middle

practice name: _____ phone: _____

office: _____ fax: _____
address city state zip

home: _____ phone: _____
address city state zip

for mailing, please use: office address home address e-mail address: _____

birthdate: _____ birthplace: _____ spouse's name: _____

medical school: _____ *name, city, state* circle one: MD or DO date completed: _____

residency program: _____ date completed: _____

medical specialty: _____ secondary specialty: _____

medical license: Kansas # _____ date: _____

licenses held in other states: _____

board certification - name: _____ date: _____

PRACTICE HISTORY

List chronologically, beginning with most recent. If additional space is required, please attach addendum.

1 _____ dates: _____
office, group or institution from to
_____ *address city state zip*

2 _____ dates: _____
office, group or institution from to
_____ *address city state zip*

3

office, group or institution

dates: _____
from to

address

city

state

zip

4

office, group or institution

dates: _____
from to

address

city

state

zip

5

office, group or institution

dates: _____
from to

address

city

state

zip

Members abide by the AMA Principles of Medical Ethics and the bylaws of the County Medical Society and the Kansas Medical Society. To assist us in upholding these standards, please provide answers to the following questions, sign and date.

If you answer yes to any of these questions, please attach full information.

YES NO

1. Have you ever been convicted of fraud or a felony?

2. Has any action, in any jurisdiction, ever been taken regarding your license to practice medicine?

This includes actions involving revocation, suspension, limitation, probation, or any other imposed sanctions or conditions.

3. Have you ever been the subject of any disciplinary action by any medical society or hospital medical staff?

I am aware that the information submitted in this application will be verified. I hereby authorize other organizations having information relating to this application, including governmental and regulatory entities, to release any and all such information.

I understand that any false or misleading statement made on my application may be grounds for denial of membership or probation or censure by, or suspension or expulsion from the medical societies.

The foregoing information is true and complete.

signature: _____

date: _____