Lexington Medical Society

In-Training Membership Application

PERSONAL INFORMATION (please print)

____ ☐ MD ☐ DO

Last Name First Middle

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Spouse's Name: ______________________

MAILING INFORMATION

Home Address: ____

Phone: ______________________ Email: ______________________

Do you prefer to receive newsletters at ☐ Home Address ☐ via Email

EDUCATION

Medical School: ______________________ Date of Graduation: __________

Residency: ______________________ Dates: __________

Specialty: ____

PHOTO NEEDED (PLEASE CHECK BOX)

☐ I GIVE LMS PERMISSION TO OBTAIN MY PHOTO (FOR PUBLICATION PURPOSES) FROM THE UK GME OFFICE.

In making this application for membership in the Lexington Medical Society, I agree to abide by the Constitution & By-laws of the Society and the Principles of Medical Ethics of the American Medical Association.

______________________________ ______________

(Signature) (Date)

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