Lexington Medical Society

Membership Application

PERSONAL INFORMATION

_____ ☐ MD ☐ DO

Last Name First Middle

Gender: ☐ Male ☐ Female Date of Birth: ____/____/_____

KY Medical Licensure #: _____ Year Licensed in KY: _____

Spouse's Name: _____

MAILING INFORMATION

Do you prefer to receive mail at ☐ OFFICE ☐ HOME

Practice/Group Name: _____ Administrator's Name: _____

Primary Specialty: _____ Secondary Specialty: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Office Email: _____ Office Website: _____

Home Address: _____

Home Phone: _____ Alternate Phone: _____

EDUCATION

Medical School: _____ Date of Graduation: _____

Internship: _____ Dates: _____

Residency: _____ Dates: _____

Fellowship: _____ Dates: _____

BOARD CERTIFICATIONS

1. Certified by the American Board of _____ Date: _____
2. Certified by the American Board of _____ Date: _____

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

_____ _____

(Signature) (Date)