Lexington Medical Society/Kentucky Medical Association

MEMBERSHIP APPLICATION

Thank you for your application!

Membership Type : ☐ Active Physician ☐ Resident/Fellow ☐ Associate

PRACTICE/PERSONAL INFORMATION

Our primary form of communication is via email

Physician's Name : ____________________

Degree(s) : ☐ MD ☐ DO ☐ MBBS ☐ MBA ☐ PhD

Practice Name : ____________________

Office Address : ____________________

Office Phone : ____________________ **Office Manager** : ____________________

Email Address : ____________________ **Med License #** : ____________________

Home Address : ____________________

Cell Number : ____________________ **Date Of Birth** : ____________________

EDUCATION/CERTIFICATIONS

Medical School : ____________________ **Date Graduated** : ____________________

Internship : ____________________ **Dates** : ____________________

Residency : ____________________ **Dates** : ____________________

Fellowship : ____________________ **Dates** : ____________________

Specialty 1 : ____________________ **Specialty 2** : ____________________

In making this application for membership to the Lexington Medical Society & Kentucky Medical Association, I agree to abide by the Constitution & Bylaws.

Lexington Medical Society
2628 Wilhite Ct, Suite 201 Lexington, KY 40503
+859-396-6094 (Cell) / cmadison@lexingtondoctors (Membership)
www.LexingtonDoctors.org

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Signature

THANK YOU FOR YOUR APPLICATION