Washoe County Medical Society

Membership Application

Membership Type/Fees:

New Active F/T:
- ☐ MD/DO: $423 (50% of regular annual fee)

Active Limited:
- ☐ MD/DO: $423 part-time

- ☐ PA — $150
- ☐ Resident/Fellow — Free
- ☐ Student — Free

Renewals:
- ☐ MD/DO *Active - Full Time* $845
- ☐ MD/DO *Active Limited - Part time* $423

WCMS Dues Payment Options

(See page 2 for options)

Section I: To Be Completed by ALL Applicants

Name: Last | First | MI | Title ☐ MD ☐ DO ☐ PA

Birth Date | Birth Place | Gender ☐ Male ☐ Female

Practice Name

Office Address: Street | City | State | Zip Code

2nd Office Address (If you have more than 2 offices, please provide additional office location information on a seperate sheet of paper): Street | City | State | Zip Code

Mailing Address: Street / PO Box | City | State | Zip Code

Office Phone #: Office | Fax | Cell | Physician Email Address ☐ I would not like to receive WCMS E-mail Notification

2nd Office Phone #: Office | Fax | Office Manager

Office Manager Email | Spouse Name

Home Address: Street | City | State | Zip Code

NV License # | Year Issued | Foreign Languages | Home Phone #

Section II: To Be Completed by Physician Assitant Applicants

Supervising Physician's Name:

Section III: To Be Completed by Physician (MD/DO) Applicants

Medical Education: School Name | Address/City/State/Zip | Degree Earned | Date Graduated

Internship: Name | Address/City/State/Zip | Date Started | Date Completed

Residency: Name | Address/City/State/Zip | Date Started | Date Completed

Fellowship: Name | Address/City/State/Zip | Date Started | Date Completed

Turn over ⇨

Date Started NV Practice _____ # Years in Nevada _____ Accepting Referrals ☐ Yes ☐ No

Primary Specialty (Attach Copy of Certification) _____ ABMS Listed Specialty _____ Board Cert Date

Secondary Specialty (Attach Copy of Certification) _____ ABMS Listed Specialty _____ Board Cert Date

Primary Practice _____

Other Board Certification _____ Name of Board _____ Date Issued

AMA Member ☐ Yes ☐ No

Credentialed at the following hospitals: _____

Within the last 5 years: *(For all "YES" answers, provide complete information on a seperate sheet of paper)*

- Have you been conviced of a felony? ☐ Yes ☐ No
- Has your license to practice medicine in any jurisdiction been limited, suspended or revoked? ☐ Yes ☐ No
- Have you been the subject of any disciplinary action by any medical society or hospital staff? ☐ Yes ☐ No

Please list three Physician references with complete Name and Address for each: *(At least one local physician reference required)*

1 _____ Physician Name _____ Address, City, State, Zip _____ Office Phone

2 _____ Physician Name _____ Address, City, State, Zip _____ Office Phone

3 _____ Physician Name _____ Address, City, State, Zip _____ Office Phone

If elected into membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of Washoe County Medical Society and Nevada State Medical Association. **Any violation of the AMA principles of medical ethics or WCMS bylaws may be cause for sanction, suspension, or termination of membership in the WCMS at the discretion of its Board of Directors, and potentially reportable to regulatory agencies where applicable.** I hereby release, and hold harmless from any liability or loss, the Washoe County Medical Society, and the Nevada State Medical Association, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability, any and all individuals and organizations, who in good faith and without malice, provide information to the above named organizations, or to their aughorized representatives, concerning my professional competence, ethical conduct, and other qualifications for membership.

_____ Applicant's Signature (no stamps) _____ Date

Mail completed application to: Washoe County Medical Society | 3700 Barron Way | Reno, NV 89511
Phone: (775) 825-0278 | Fax: (775) 825-0785

Email photo (.jpg or .tiff) to: admin@wcmsnv.org **An electronic photograph is required to complete the applications process.** Please email the photograph or visit the WCMS office to have a digital phot taken.

How did you hear about us?

☐ WCMS Website ☐ Colleague (please provide name) _____	☐ Health Insurance Co. (please specify) _____ ☐ Hospital	☐ Malpractice Insurance Co. _____ ☐ Other (please specify) _____

Method of Payment

Credit Card | Check

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover Amount:_____

Credit Card Number

__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/ Exp. Date __/__

Name on Card: _____ SC:____

Billing Address: _____ Zipcode:____

_____
Credit Card Signature Authorization

☐ Check Amount $_____ Check # _____

Make check payable to: Washoe County Medical Society or WCMS

Mail To: Washoe County Medical Society
3700 Barron Way
Reno, NV 89511

Fax: 775-825-0785