



WAKE COUNTY MEDICAL SOCIETY

Application for Membership

Physician

Please read carefully and provide all requested information.

BIOGRAPHICAL INFORMATION

Name: _____

Email address: _____ Spouse Name: _____

Home Address: _____

Zip: _____ Phone: _____ Preferred Mailing: () Home () Office

Date of Birth: _____ Gender: () M () F

Languages Spoken other than English: _____

Medical Specialty (1st): _____ (2nd): _____

North Carolina Medical License #: _____ Date of Issuance: _____

Year Began Practice in Wake: _____

Medical School Graduated From: _____ Year Graduated _____

Last Year of Training: _____

PRACTICE INFORMATION

Practice Name: _____

Primary Office Address: _____

Zip: _____ Phone: _____ Fax: _____

Secondary Office Address: _____

Zip: _____ Phone: _____ Fax: _____

Practice Manager: _____ E-mail address: _____

Please send information about **Project Access** (100% Access – 0% Disparity) Yes _____

COUNTY DUES = \$200.00

Make check payable to *Wake County Medical Society* and send to:
2500 Blue Ridge Road, Suite 312, Raleigh, NC 27607

CK # _____
Notified NCMS _____

Ph: (919) 783-0404 Fax: (919) 510-9162