



APPLICATION FOR MEMBERSHIP WAKE COUNTY MEDICAL SOCIETY Physician Assistant

Please read carefully and provide all requested information.

BIOGRAPHICAL INFORMATION

Name: _____
Email address: _____ Spouse Name: _____
Home Address: _____
Zip: _____ Phone: _____ SS #: _____
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: _____
E-Mail Address: _____ Year Began Practice in Wake: _____

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 – PHYSICIAN ASSISTANTS = \$130.00

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

CK # _____

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

Notified NCMS _____