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 (Physicians) = $200.00
Make check payable to *Wake County Medical Society* and send to:
2500 Blue Ridge Road, Suite 330, Raleigh, NC 27607
(919) 792-3623 – Membership
(919) 510-9162 – Fax

OFFICE USE ONLY

CK #___________
Notified NCMS______