

# APPLICATION FOR MEMBERSHIP

## WILL-GRUNDY COUNTY MEDICAL SOCIETY ILLINOIS STATE MEDICAL SOCIETY

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### APPLICANT INFORMATION

Applicant (please print): \_\_\_\_\_ M.D. D.O.

Office Address: \_\_\_\_\_  
STREET  
CITY STATE ZIP

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Place Of Birth: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M F

Specialty: \_\_\_\_\_ Type Of Practice: Group Solo

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### EDUCATION

Undergraduate Institution: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Medical School: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Residencies/Internships/Fellowships:

Hospital: \_\_\_\_\_ Type: \_\_\_\_\_ Years(s): 19\_\_\_\_ - \_\_\_\_

Hospital: \_\_\_\_\_ Type: \_\_\_\_\_ Years(s): 19\_\_\_\_ - \_\_\_\_

Hospital: \_\_\_\_\_ Type: \_\_\_\_\_ Years(s): 19\_\_\_\_ - \_\_\_\_

Year Illinois Medical License received: \_\_\_\_\_ License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_

Hospital on staff: \_\_\_\_\_

Has your license to practice medicine ever been suspended or revoked? Yes No

Have your hospital privileges ever been suspended or revoked? Yes No

Has your participation in any internship or residency program been terminated prior to its conclusion? Yes No

*If you have answered yes to any of the above three questions, please provide an explanation on the reverse side of this application.*

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### Other medical organization memberships (specialty societies, etc.):

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

Board Certification(s): \_\_\_\_\_ Year: \_\_\_\_\_

\_\_\_\_\_ Year: \_\_\_\_\_

Residential Address: \_\_\_\_\_  
STREET

CITY STATE ZIP

Spouses Name (if applicable): \_\_\_\_\_

I hereby make application for membership in the Will-Grundy Medical Society, Illinois State Medical Society, and if admitted as a member, I agree to support its Constitution and Bylaws, to practice in accordance with the established usages of the profession, and will in no way profess adherence or give my support to any exclusive dogma or school.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE CONTACT THE WILL-GRUNDY MEDICAL SOCIETY WITH ANY QUESTIONS**

Will-Grundy County Medical Society  
3033 W. Jefferson Street  
Suite #220  
Joliet, IL 60435

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Fax (815) 744-7557  
[Wgcms3033@att.net](mailto:Wgcms3033@att.net)