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APPLICATION for MEMBERSHIP

Please Print or Type

1. FULL NAME OF APPLICANT		2. Sex	3. SPOUSE'S NAME:	
4. PRACTICE NAME		5. PRACTICE ADDRESS - ZIP		6. PRACTICE PHONE: _____ FAX: _____
7. HOME ADDRESS		8. HOME TELEPHONE		9. E-MAIL
10. PLACE OF BIRTH		11. DATE OF BIRTH Mo _____ Day _____ Year _____		12. SOCIAL SECURITY NUMBER
13. MEDICAL EDUCATION (Current Name of School)		14. DATE OF MD DEGREE		15. YEAR OF INITIAL LICENSE: _____ LICENSE(S) HELD IN OTHER STATES & YEAR ISSUED: _____
16. POST GRADUATE TRAINING (Name of Institution & Location) _____ _____ _____		17. INCLUSIVE DATES OF TRAINING _____ _____ _____		18. ARE YOU BOARD CERTIFIED? YES ____ NO ____ IF YES, WHAT SPECIALITY? _____ 19. LAST YEAR OF TRAINING:
20. NORTH CAROLINA LICENSE NUMBER	21. DATE ISSUED	22. BY EXAMINATION _____ BY RECIPROCITY _____		23. BEGAN PRACTICE AT PRESENT LOCATION ON DATE _____ SPECIALTY _____
24. LIST HOSPITALS WHERE YOU HAVE CURRENT PRIVILEGES:				

25. If elected to membership, I agree without reservation to conduct myself professionally and personally according to the principles and medical ethics of the American Medical Association and to be governed by the Constitution and Bylaws of the Greater Greensboro Society of Medicine & the North Carolina Medical Society.

26. _____, MD
 Signature _____
 Date: _____

WE, THE UNDERSIGNED SPONSORS, EARNESTLY RECOMMEND THIS PHYSICIAN'S ELECTION TO MEMBERSHIP

SPONSOR _____, MD Signature _____ _____, MD Print Name _____	SPONSOR _____, MD Signature _____ _____, MD Print Name _____	SPONSOR _____, MD Signature _____ _____, MD Print Name _____
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MEMBERS OF THE EXECUTIVE COMMITTEE, HAVE CAREFULLY REVIEWED THIS APPLICATION AND RECOMMEND:

APPROVAL - REJECTION _____, MD	APPROVAL - REJECTION _____, MD
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This Applicant was elected to Membership on: _____

_____, MD
 (SECRETARY SIGNATURE)