



# MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

860 WINTER STREET, WALTHAM, MA 02451-1411

TEL (781) 893-4610

WWW.MASSMED.ORG

## RESIDENT/FELLOW APPLICATION FOR MEMBERSHIP

Join online at [www.massmed.org/join](http://www.massmed.org/join)

Please type or print clearly.

DATE \_\_\_\_\_

NAME \_\_\_\_\_ [ ] MD [ ] DO  
FIRST MIDDLE LAST

EMAIL \_\_\_\_\_ [ ] HOME [ ] OFFICE FAX \_\_\_\_\_ [ ] HOME [ ] OFFICE

OFFICE ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ MOBILE PHONE \_\_\_\_\_

PREFERRED MAILING ADDRESS [ ] HOME [ ] OFFICE (Complete mailing address required.) PREFERRED BILLING ADDRESS [ ] HOME [ ] OFFICE

BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ [ ] MALE [ ] FEMALE [ ] PREFER NOT TO IDENTIFY NPI NUMBER \_\_\_\_\_

Has your application for membership in a medical society ever been disapproved, or have you ever been suspended or expelled from membership in a medical society? [ ] YES [ ] NO

Has your license to practice medicine in any state ever been revoked or suspended? [ ] YES [ ] NO

Have you ever been convicted of a felony? [ ] YES [ ] NO

If the answer is yes to any of these, please send details in a separate letter.

### Residency and Fellowship Training Program Receives FREE Group Membership

Residents and Fellows become MMS members FREE of charge when all of the Residents and Fellows within an accredited residency training program enroll as a group. Ask your Program Director or Coordinator to contact [groups@mms.org](mailto:groups@mms.org) or (781) 434-7143.

The Massachusetts Medical Society membership year runs from January 1 to December 31 and encompasses state and district medical society dues. Standard annual state medical society dues are \$60. Standard annual resident district medical society dues may be up to \$30 annually (see back panel). Membership in a district medical society is required. For more information, visit [www.massmed.org/dues](http://www.massmed.org/dues).

1 [ ] \$150 FOR 3 YEARS (3 years of district dues where applicable) [ ] \$60 FOR 1 YEAR ENTER STATE DUES TOTAL \$ \_\_\_\_\_

2 DISTRICT (See back panel.) \_\_\_\_\_ DUES \$ \_\_\_\_\_ I [ ] WORK [ ] RESIDE IN THIS DISTRICT.

3 MULTIPLY DISTRICT AMOUNT IN #2 BY NUMBER OF YEARS SELECTED IN #1. ENTER DISTRICT DUES TOTAL \$ \_\_\_\_\_

4 TOTAL DUES ENCLOSED \$ \_\_\_\_\_

PAYMENT OPTIONS: [ ] ONLINE AT [WWW.MASSMED.ORG/JOIN](http://WWW.MASSMED.ORG/JOIN) [ ] CHECK ENCLOSED (Make payable to Massachusetts Medical Society or MMS.)

CHARGE MY CREDIT CARD: [ ] VISA [ ] MASTERCARD [ ] AMERICAN EXPRESS

CARD NO. \_\_\_\_\_ CSV CODE \_\_\_\_\_ EXPIRATION DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that all of the above statements are true. I agree to comply with the MMS Code of Ethics ([www.massmed.org/codeofethics](http://www.massmed.org/codeofethics)).

SIGNATURE \_\_\_\_\_ PLEASE PRINT NAME \_\_\_\_\_

RECRUITED BY \_\_\_\_\_

Signed application should be returned to: **MMS Membership Processings**  
860 Winter Street  
Waltham, MA 02451-1411

Questions?  
Email [mmsprocessing@mms.org](mailto:mmsprocessing@mms.org) or  
call (617) 841-2925

AMA MEDICAL EDUCATION NUMBER \_\_\_\_\_

SPECIALTY \_\_\_\_\_

MASSACHUSETTS LICENSE NUMBER \_\_\_\_\_ DATE INITIALLY RECEIVED \_\_\_\_/\_\_\_\_/\_\_\_\_

MEDICAL SCHOOL \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ COUNTRY \_\_\_\_\_

YEAR GRADUATED \_\_\_\_\_

DEGREES (Please list all postgraduate educational degrees and designations.) \_\_\_\_\_

CURRENT STATUS  PRELIMINARY YEAR (if applicable)  RESIDENT  FELLOW

TRAINING (List hospital name and address.)

PRELIMINARY YEAR (if applicable)  RESIDENCY  FELLOWSHIP

PROGRAM NAME (specialty) \_\_\_\_\_

HOSPITAL \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

BEGIN DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ COMPLETION DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

RESIDENCY  FELLOWSHIP

PROGRAM NAME (specialty) \_\_\_\_\_

HOSPITAL \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

BEGIN DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ COMPLETION DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

RESIDENCY  FELLOWSHIP

PROGRAM NAME (specialty) \_\_\_\_\_

HOSPITAL \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

BEGIN DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ COMPLETION DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

AMERICAN MEDICAL ASSOCIATION RESIDENT/FELLOW MEMBERSHIP (OPTIONAL)

I would like the Massachusetts Medical Society to pay for an AMA membership on my behalf. FREE to MMS Resident/Fellow Members (\$45 value).

 Signature \_\_\_\_\_ Please Print Name \_\_\_\_\_

Conditions of AMA membership and application:

As part of a physician organization committed to strengthening the ethics of medicine, every member pledges to uphold the Principles of Medical Ethics as interpreted in the Code of Medical Ethics, and to comply with the Bylaws of the American Medical Association and the Rules of the AMA Council on Ethical and Judicial Affairs.

- The AMA Principles and the Code of Medical Ethics: [code-medical-ethics.ama-assn.org](http://code-medical-ethics.ama-assn.org)
- The AMA's Bylaws and Rules of the Council on Ethical and Judicial Affairs: [www.ama-assn.org/go/ceja](http://www.ama-assn.org/go/ceja)

Applicants and members are required to disclose to the AMA Office of General Counsel any violations of the Principles of Medical Ethics or unprofessional conduct including actions taken regarding professional licensure, medical staff privileges, or felony or fraud convictions. Additionally, the Health Care Quality Improvement Act requires professional societies (such as the AMA) to report certain professional review actions, including denial of membership, to the National Practitioner Data Bank.

STANDARD ANNUAL DISTRICT MEDICAL SOCIETY RESIDENT/FELLOW DUES

Barnstable <i>None</i>	Bristol South <i>None</i>	Essex South <i>None</i>	Hampshire <i>None</i>	Middlesex North \$25	Norfolk South <i>None</i>	Worcester \$30
Berkshire <i>None</i>	Charles River <i>None</i>	Franklin <i>None</i>	Middlesex <i>None</i>	Middlesex West <i>None</i>	Plymouth <i>None</i>	Worcester North <i>None</i>
Bristol North <i>None</i>	Essex North <i>None</i>	Hampden \$25*	Middlesex Central <i>None</i>	Norfolk \$30	Suffolk \$10	

\*Hampden District Medical Society dues will be waived for individual residents and fellows participating in graduate medical education programs affiliated with Baystate Health. Please contact [mmsprocessing@mms.org](mailto:mmsprocessing@mms.org) for eligible refunds.

FOR SOCIETY USE ONLY

THIS APPLICATION HAS BEEN APPROVED ON \_\_\_\_\_ BY THE \_\_\_\_\_ DISTRICT MEDICAL SOCIETY.

SIGNED \_\_\_\_\_