# WHATCOM COUNTY MEDICAL SOCIETY
## PHYSICIAN ASSISTANT APPLICATION FOR MEMBERSHIP

### PERSONAL INFORMATION

Name _____ Email Address: _____
Last First Middle Initial

Birthplace _____ Date of Birth _____ Social Security No. _____

Citizenship _____ Foreign Language(s) _____ Spouse's Name _____

Home Address _____ Home Phone _____

### EMPLOYMENT INFORMATION

Clinic Name: _____ Office Address _____

Office Phone _____ Office Fax _____ Email Address. _____

Employed By (name of WCMS physician member): _____

### EDUCATION

COLLEGE/UNIVERSITY: _____
name address state

Degree Conferred _____ Date Graduated _____

COLLEGE/UNIVERSITY: _____
name address state

Degree Conferred _____ Date Graduated _____

### LICENSING

Washington State License No. _____ Date Issued _____

Other State License No. _____ Date Issued _____

Other State License No. _____ Date Issued _____

Have your privileges at any hospital ever been suspended, denied, diminished, revoked or not renewed? _____ Yes _____ No
Have judgments or settlements been made against you in professional liability cases or are there any pending? _____ Yes _____ No

I, the undersigned applicant, certify that I have read the Constitution and Bylaws of the Whatcom County Medical Society, and the Constitution and Bylaws of the Washington State Medical Association, and the Principles of Medical Ethics of the American Medical Association, and agree, in case of my election, that my membership in the Society shall be conditional upon by continued compliance with such Constitutions, Bylaws and Principles. I further agree that I will recognize and abide by the interpretation thereof by the authorized officers of the Society and Association, reserving my rights of appeal as set forth in the Constitution and Bylaws of this Society.

Recommended by:

_____
(Signature of current WCMS member)

_____
(Signature of current WCMS member)

Submitted by:

_____
SIGNATURE OF APPLICANT