

MEMBERSHIP APPLICATION



LAST NAME: _____ **MIDDLE:** _____ **FIRST:** _____

Clinic Name: _____
Address: _____

Telephone: () _____
Clinic Fax: () _____
County: _____
Email: _____

Home Address: _____

Personal URL: _____

Telephone: () _____
Mobile Phone: () _____
County: _____

Preferred Mailing Address: () Home () Clinic

Preferred E-mail Address: () Home () Clinic

Date of Birth: _____

Male: () **Female:** ()

Applicant's Prior Name (i.e. maiden name): _____

Spouse's Full Name (if applicable): _____

Primary Specialty: _____

Secondary Specialty (ies): _____

	<u>Location:</u>	<u>Specialty:</u>	<u>Date Started:</u>	<u>Date Completed:</u>
Medical School	_____		_____	_____
Internship/Residency	_____	_____	_____	_____
Internship/Residency	_____	_____	_____	_____
Fellowship	_____	_____	_____	_____

Hospital Staff Affiliations: _____

Form of Practice: () Direct Patient Care () Research () Administration
() Teaching () Other: _____

Current Work Status: () Full Time () Part-Time () Retired () Other: _____

Average hours worked per week: _____

Minnesota License #: _____ **Date Issued:** _____ **Medical Education #:** _____

SIGNATURE: _____ **DATE:** _____