MILWAUKEE GYNECOLOGICAL SOCIETY
APPLICATION FOR MEMBERSHIP

NAME____ MD / DO_____

EMPLOYER NAME____

OFFICE ADDRESS ____

CITY______________________________ STATE______ ZIP________________

OFFICE PHONE (__________)____________________ FAX (_______)____________________

E-MAIL ADDRESS____

I hereby make application for membership in the Milwaukee Gynecological Society, and if accepted as a member, I agree to support its constitution and bylaws, to practice in accordance with the established usages of the profession and in no way profess adherence or give my support to any exclusive dogma or school.

Membership Dues:
____ **Active Member: $250** (Candidate must be **Board Certified** in OB-GYN)
____ **Associate Member: $250** (Candidate must be **Board Eligible** in OB-GYN)
____ **Life Member: $150** (Candidate must be retired from practice and age 65 or older)

METHOD OF PAYMENT
☐ Check (payable to *Milwaukee Gynecological Society*)
☐VISA ☐MasterCard ☐Discover Card Number: ______________________________
Expiration Date: ______ Security Code: _______ Name on Card: ______________________________

SIGNATURE______________________________ DATE____________________

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PREMEDICAL EDUCATION DATES (INCLUSIVE) DEGREE

College______________________ ______________ ______________

MEDICAL EDUCATION

University______________________ ______________ ______________

INTERNSHIP DATES (INCLUSIVE)

Hospital______________________________ ______________

RESIDENCIES DATES (INCLUSIVE)

Hospital______________________________ ______________

Hospital______________________________ ______________

POST GRADUATE EDUCATION DATES (INCLUSIVE) DEGREE

University______________________ ______________ ______________

ASSISTANTSHIPS OR ASSOCIATIONS DATES (INCLUSIVE)

Name______________________________ ______________

HOSPITAL STAFF APPOINTMENTS TYPE OF APPOINTMENTS DATE STARTED

Hospital______________________ ______________ ______________

Hospital______________________ ______________ ______________

TEACHING APPOINTMENTS DEPARTMENT POSITION DATES (INCLUSIVE)

University______________ ______________ ______________ ______________

University______________ ______________ ______________ ______________

MEMBERSHIP IN MEDICAL SOCIETIES

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WISCONSIN LICENSE (DATE)____________________ OTHER STATES________________

CERTIFICATION BY SPECIALTY BOARD ______________ DATE OF CERTIFICATION: __________

MILITARY SERVICE BRANCH ____________________ DATES (INCLUSIVE): ______________