GREATER LOUISVILLE MEDICAL SOCIETY
1892

101 West Chestnut Street
Louisville, Kentucky 40202-1881
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www.glms.org

Formerly Jefferson County Medical Society

# APPLICATION FOR MEMBERSHIP

**Please check the organization(s) to which you are applying**

- ☐ **Greater Louisville Medical Society and Kentucky Medical Association**
- ☐ **American Medical Association**

**PLEASE NOTE: The application cannot be processed unless all requested information and the following attachments are provided.**

1. **Application must be typed or printed legibly**
2. **Photo for GLMS Roster**
3. **Copy of current medical, dental or professional license**
4. **All sections of the application must be compelted; "see CV', "see attachment", etc., is not acceptable**

## I. PERSONAL IDENTIFICATION DATA

Name: _____
Last Suffix First Middle Maiden Name: Degree

Primary Mailing Address: _____

Residence: _____ Phone: _____

1st Office Address: _____ Phone: _____

2nd Office Address: _____ Phone: _____

Primary Fax: _____ Email: _____ Web Address: _____

Date of Birth: _____ Gender: _____ Place of Birth: _____

Social Security #: _____ Marital Status: _____

Citizenship: _____ Spouse's Name: _____

If not a citizen of the United states, please indicate the status of your visa at the present time: _____

Languages Spoken: _____

ECFMG #: ☐ ☐☐☐ ☐☐☐ ☐

Clinical Specialty/Subspecialty: _____

Other interests in practice, research, etc. _____

Name others with whom you are or will be associated in practice:

Nature of association: ☐ Solo ☐ Group ☐ Partnership ☐ Corporation Effective Date: _____

Other: (please specify) _____

Name of Practice: (if applicable) _____

Covering physician to be called in my absence:

_____ Telephone: _____

## II. EDUCATIONAL DATA

**(all periods of time must be accounted for from entrance into medical school to the present)**

### A. SCHOOLS

Undergraduate College/University: _____

Address: _____

City/St/Zip: _____

City St Zip Zip + Country

Degree: _____ / _____

From To

Medical/Dental/Other College: _____

Address: _____

City/St/Zip: _____

City St Zip Zip + Country

Degree: _____ / _____

From To

### B. INTERNSHIPS

Name: _____ _____ / _____

Type of Internship From To

Address: _____

City/St/Zip: _____

City St Zip Zip + Country

Phone: _____ Fax: _____

During this internship were you ever suspended, placed on probation, formally reprimaned or asked to resign?

If YES, please explain on a separate sheet and attach. ☐ Yes ☐ No ☐ Attachment

### C. RESIDENCIES

Name: _____ _____ / _____

Type of Residency From To

Address: _____

City/St/Zip: _____

City St Zip Zip + Country

Phone: _____ Fax: _____

Chairman/Chief of Service: _____

Did you complete the residency? ☐ Yes ☐ No

During this residency were you ever suspended, placed on probation, formally reprimaned or asked to resign?

If YES, please explain on a separate sheet and attach. ☐ Yes ☐ No ☐ Attachment

**D. FELLOWSHIPS and/or OTHER POSTGRADUATE TRAINING**

Name: _____ _____ / _____
Type of Fellowship From To

Address: _____ _____

City/St/Zip: _____
City St Zip Zip + Country

Phone: _____ Fax: _____

Chairman/Chief of Service: _____

Did you complete the fellowship? ☐ Yes ☐ No

During this fellowship were you ever suspended, placed on probation, formally reprimaned or asked to resign?
If YES, please explain on a separate sheet and attach. ☐ Yes ☐ No ☐ Attachment

**E. OTHER PROFESSIONAL TRAINING**

School: _____ _____ / _____
Chairman/Chief of Service From To

Address: _____ _____

City/St/Zip: _____
City St Zip Zip + Country

Phone: _____ Fax: _____

Degree: _____

School: _____ _____ / _____
Chairman/Chief of Service From To

Address: _____ _____

City/St/Zip: _____
City St Zip Zip + Country

Phone: _____ Fax: _____

Degree: _____

## III. LICENSURE INFORMATION

**(This application cannot be processed without current copy of Medical or Dental License in the state to which you are applying.) List all current and past professional health care licenses held.**

| | State of Issue: | Number: | Date Issued: | Expiration: | License obtained by: | |
|---|---|---|---|---|---|---|
| KY State: | | | | | ☐ **Examination** | ☐ **Reciprocity** |
| IN State: | | | | | ☐ **Examination** | ☐ **Reciprocity** |
| State #3: | | | | | ☐ **Examination** | ☐ **Reciprocity** |
| State #4: | | | | | ☐ **Examination** | ☐ **Reciprocity** |
| State #5: | | | | | ☐ **Examination** | ☐ **Reciprocity** |
| State #6: | | | | | ☐ **Examination** | ☐ **Reciprocity** |
| State #7: | | | | | ☐ **Examination** | ☐ **Reciprocity** |

State #8: _____ _____ _____ _____ ☐ **Examination** ☐ **Reciprocity**

**If licensed in more than eight (8) states, please supply the same information on a separate sheet and attach.**

## IV. CERTIFICATION BY AMERICAN BOARD OF MEDICAL SPECIALTIES

**(This application cannot be processed without proof of American Board Status.)**

1. Are you board certified? ☐ Yes ☐ No
2. If yes, list full name of certifying board and date which you obtained certification/recertification:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

3. If you are not yet certified but have applied to a specialty board for examination, give the name of the board and date of application:

_____ Date: _____

4. If status is one of eligibility, provide year when eligibility will terminate under rules of the specific board: _____
5. List date of next required recertification (if applicable) _____

## V. PRACTICE INFORMATION

**Please answer each of the following questions in full. If the answer to any question is "yes," please provide full explanation of the details on a separate sheet and attach.** ☐ Attachments

1. Have you had any professional license or certification in any state that has ever been denied, limited, suspended, sanctioned, revoked, probated, voluntarily or involuntarily relinquished or not renewed? ☐ YES ☐ NO
2. Have you been named as a defendant or convicted of a felony or misdemeanor? ☐ YES ☐ NO
3. Have you ever been denied membership or renewal thereof, or been subject to disciplinary or adverse action in any medical or professional organization? ☐ YES ☐ NO

## VI. PROFESSIONAL ASSOCIATIONS

**Membership in Professional Societies (local, state or national)** ☐ Attachment **Dates** **From** **To**

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

Name: _____
Address: _____
City: _____ State: _____ Zip: _____

**Professional Colleges** **Date of Membership**

Name: _____
Name: _____

**Professional Academies**

Name: _____
Name: _____

## VII. PEER REFERENCES

**Provide the names and complete addresses of three peers who have worked extensively with you, including personal observation of your clinical performance. EXCLUDE MEDICAL TRAINING DIRECTORS AND RELATIVES**

Reference: _____

Address: _____ Phone: _____

City/St/Zip: _____ Email: _____

Reference: _____

Address: _____ Phone: _____

City/St/Zip: _____ Email: _____

Reference: _____

Address: _____ Phone: _____

City/St/Zip: _____ Email: _____

## VIII. AUTHORIZATION AND RELEASE OF APPLICANT

**(Please read carefully before signing)**

I hereby apply for membership in the Greater Louisville Medical Society ("Society") and, as a condition of my application/membership, agree to be bound by its bylaws. As a condition of applying for/accepting membership in the Society, and whether of not my application is accepted, I acknowledge, consent, and agree as follows:

I will make myself available for interviews and acknowledge the burden of producing updated current information as to all questions on this application and such other information reasonably necessary to evaluate my qualifications. I authorize all persons and organizations having any knowledge of such matters to release said information to the Society or its authorized representatives upon request and I consent to the reporting of disciplinary information pertinent to Society membership.

Information and documents derived from or compiled in connection with this application shall be privileged and confidential to the fullest extent permitted by law.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application.

Applicant's Signature _____ Date _____