

**APPLICATION FOR MEMBERSHIP TO
THE _____ COUNTY MEDICAL SOCIETY AND
THE MEDICAL SOCIETY OF NEW JERSEY**

Name _____ (Exactly as on NJ Medical License)

Medical Education Number _____ (If M.E. # unknown, leave blank.)

NJ Medical License # _____ Date Issued _____ Birth Date _____ Sex _____

Send mail to: ☐ Primary Practice ☐ Secondary Practice ☐ Home

Primary Practice _____ (_____) _____
GROUP NAME (if applicable) TELEPHONE NUMBER

STREET _____ FAX NUMBER

CITY, STATE, ZIP _____

Secondary Practice _____ (_____) _____
GROUP NAME (if applicable) TELEPHONE NUMBER

STREET _____ FAX NUMBER

CITY, STATE, ZIP _____

Home _____ (_____) _____
STREET TELEPHONE NUMBER

CITY, STATE, ZIP _____ FAX NUMBER

Spouse's Name _____ E-Mail Address _____

Past MSNJ member: No ____ Yes ____ County: _____ Current AMA Member: Yes ____ No ____

Medical Education _____
School/Location Degree Year

Residencies/Dates _____

Fellowship/Dates _____

Specialty Areas – Primary: _____ Secondary (if any): _____

Board Certification(s) _____

List any specialty society in which you are a Fellow _____

Active Hospital Appointments _____

Please answer the following. Attach a full explanation to any questions answered "yes."

Have you ever been convicted of a felony crime? Yes ____ No ____

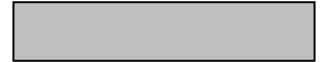
Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked? Yes ____ No ____

Have you ever been the subject of any disciplinary action by any medical licensing board,
medical society, or hospital staff? Yes ____ No ____

I hereby release, and hold harmless from any liability or loss, the _____ County Medical Society and Medical Society of New Jersey, their officers, agents, employees, & members for acts performed in good faith & without malice in connection with evaluating any application & my credentials & qualifications, & hereby release from any liability any & all individuals & organizations, who, in good faith & without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character & other qualifications for membership. Furthermore, I attest to the accuracy of information supplied on this application & understand that falsification of any information may result in denial or revocation of membership.

Applicant's signature: _____ Date: _____

Return completed application to: MSNJ, Two Princess Rd., Lawrenceville, NJ 08648 Questions? 1-800-322-MSNJ.



Section 1: To be completed by county medical society staff

Applicant's name: _____ County: _____

Date application received: _____ Applicant recruited by: _____

AMA Profile obtained ☐ via modem ☐ requested from MSNJ

This applicant is being considered for new membership or reinstatement of membership as:

- ☐ associate member (non-licensed in NJ) ☐ licensed resident membership
☐ active membership ☐ active membership by transfer from _____

Section 2: To be completed by county medical society membership review body

The _____ of the _____ County Medical Society has reviewed this application and in accordance with the By-Laws of the Medical Society of New Jersey it is hereby being submitted for review and action of the Committee on Credentials of the Medical Society of New Jersey.

Print Name

Title (within County Medical Society)

Signature

Date of Action

**ATTACH AMA BIOGRAPHICAL INFORMATION FORM AND SUBMIT TO MEMBERSHIP DEPARTMENT,
MEDICAL SOCIETY OF NEW JERSEY, TWO PRINCESS RD., LAWRENCEVILLE, NJ 08648-2302.**

Section 3: To be completed by state medical society membership department staff

Date received _____ AMA Profile attached ☐ yes
Reviewed by _____ Licensing action noted ☐ yes ☐ no
Sent for review by ☐ District #____ Judge Date _____
☐ Credentialing Committee Chair Date _____

Section 4: If applicable, to be completed by District

I have reviewed the information on this application and find the applicant

☐ satisfactory for membership ☐ unsatisfactory for membership for the reason(s) stated below:

Signature _____ Date _____

Section 5: To be completed by the Chair, MSNJ Committee on Credentials

I have reviewed the information on this application and find the applicant

☐ satisfactory for membership ☐ unsatisfactory for membership for the reason(s) stated below:

Signature _____ Date _____

Section 6: To be completed by MSNJ Membership Staff

Credential review received at Medical Society of New Jersey on _____.