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**For Office Use Only**

Received \_\_\_\_\_

Entered \_\_\_\_\_

Paid \_\_\_\_\_

**APPLICATION for MEMBERSHIP**  
**Please Print or Type**

1. FULL NAME OF APPLICANT <input type="checkbox"/> MD <input type="checkbox"/> PA		2. Sex	3. SPOUSE'S NAME:
4. PRACTICE NAME	5. BUSINESS ADDRESS		6. BUSINESS PHONE: FAX:
7. HOME ADDRESS		8. HOME TELEPHONE	9. E-MAIL
10. PLACE OF BIRTH	11. DATE OF BIRTH Mo _____ Day _____ Year _____		12. SOCIAL SECURITY NUMBER
13. MEDICAL EDUCATION (Current Name of School)		14. DATE OF MD DEGREE	15. YEAR OF INITIAL LICENSE:  LICENSE(S) HELD IN OTHER STATES & YEAR ISSUED:
16. POST GRADUATE TRAINING (Name of Institution & Location) _____ _____ _____ _____		17. INCLUSIVE DATES OF TRAINING _____ _____ _____ _____	
18. ARE YOU BOARD CERTIFIED? YES ____ NO ____  IF YES, WHAT SPECIALITY? ----- 19. Last Year of Training?			
20. NORTH CAROLINA LICENSE NUMBER	21. DATE ISSUED	22. BY EXAMINATION _____ BY RECIPROCITY _____	23. BEGAN PRACTICE AT PRESENT LOCATION ON DATE _____ SPECIALTY _____
24. LIST HOSPITALS WHERE YOU HAVE CURRENT PRIVILEGES			

25. If elected to membership, I agree without reservation to conduct myself professionally and personally according to the principles and medical ethics of the American Medical Association and to be governed by the Constitution and Bylaws of the High Point Medical Society and North Carolina Medical Society.

26. (SIGNED) \_\_\_\_\_, MD  
 DATE \_\_\_\_\_

**WE, THE UNDERSIGNED SPONSORS, EARNESTLY RECOMMEND THIS PHYSICIAN'S ELECTION TO MEMBERSHIP**

SPONSOR _____, MD Print Name Below	SPONSOR _____, MD Print Name Below	SPONSOR _____, MD Print Name Below
_____, MD	_____, MD	_____, MD

**WE THE UNDERSIGNED CENSORS, HAVE CAREFULLY REVIEWED THIS APPLICATION AND RECOMMEND:**

APPROVAL - REJECTION _____, MD	APPROVAL - REJECTION _____, MD
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**THIS APPLICANT WAS ELECTED TO MEMBERSHIP ON:** \_\_\_\_\_, MD  
 (SECRETARY)